Physicia	n
/Medica	ı
Examine	r

Director

Funeral

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Funeral Director

23a or 28a-f ahow the Medical Examiner must be notified at death ō natural other h and Mental F . Pages 1 and 2 should be treent of Health and Menta tant: If item 27 is marked or other permit. Page Department o Important: If any injury or once.

Maryland 21215-0036

Baltimore,

FORI

Physician /Medical Examiner

or Attending Physician; The law requires that the death certificate be executed After

Ö م Records. Division of Vital the funeral director, within 24 hours after death.

To the Funeral Diractor: A
completely filled in by the fu To the Hospital

Examiner Be Completed by Physician/Medical Certification: To Medical

Completed Be 2 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 | Homicide

29a. Certifier

1 - State Registrar Amend item #5 Per FH C851 1/23/06 JH of Death 1. Decedent's Name (First, Middle, Last) Time of Death Year 9:02 PM 01 2006 CLIFFORD E. PERRY 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HUSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Social Security Number Hours 1, M 2□ F Months Days 230-14-2370 Usual Residence of Decedent NORTH CAROLINA 89 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 No BALTIMORE PARKVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 8028 DALESFORD ROAD USA 12. Was Decedent Ever in U.S. Armed Forces? 1 [XYes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married WHITE 1 ☐ Yes 2 ☐ No Specify: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MACHINIST AUTOMOTIVE 7TH GRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) FRANKLIN PERRY MAUDE WOOD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Date 20c. Location - City or Town, State HETTIE B. PERRY/WIFE 20b. Place of Disposition (Name of 20a. Method of Disposition DULANEY VALLEY MEM. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 1/21/2006 COCKEYSVILLE, MD GARDENS 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses 8527 LOCH RAVEN BLVD. TOWSON, MD Ant Enter the disease, or complications that cases the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of) LOLITIS Sequentially list conditions, 1 any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last RENAL FAILURE Due to (or as a consequence of 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of deliver 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION CORONARY ARTERY DISEASE

ATRIAL FIBRILLATION, CHRONIC OBSTRUCTIVE

PULMONARY DISEASE, HYPOTHYROIDISM 26. Place of Death | Check only one

Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and monner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

24a. Was an autopsy performed

2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

BALTIMORE MD 21239

1 ☐ Yes

29b. Signature and title of certific completed cause of death (Item 23a) (Type, Print)

1/18/2006 5601 WICH RAVEN

Year

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

GOUD SAMARITAN HOSPITAL JIMMY MHENRY MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

5 Pending investigation



DHMH 17 Rev 1/2001

State Registrar

			for State Registrar		State of	Maryla				ealth a	and M	lental Hyg	iene _{eg. No.} 20	06	01002
47.	Physic	e e	Decedent's Name (First	st, Middle, Last,			n Ploc	 h				2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medi						:11 F10C					January	13, 20	06	12:12 A M
1.	Exami	ner	4a. Facility Name (If not i	_						Location o			4c. County		
~	· · · · · · · · · · · · · · · · · · ·	*	Johns Hopk: 5. Social Security Number				Ctr. last birthday)		Balt 1 Year	imore		-		/A	land (Chata as Carrier
100	Funeral Director		215-05-5609 Usual Residence of Dece	9 1	M 21∏F	90	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, Dec. 2	Year) 2,1915	Сои	place (State or Foreign ntry) yLand
	yland yland		10a. State 10b.	County		10c. C	ity, Town or Lo	cation						1	10d. Inside City Limits
	hours after death with the Maryland turel', or items 23a or 28a-f ehow at Everilli at must be notified at	ţò	Maryland	Bal	timore				Dund	alk					1 ☐ Yes 2X No
	in the	Director	10e. Street and Number					10f. Zip	Code			1	0g. Citizen of W	/hat Cou	ntry?
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	ems ems	Funeral	11. Marital Status		12. Was Decede Armed Force		J.S. 13.	Vas Dece	dent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		- Americk, White,	can Indian,
98	or it	F	1 Never Married		1 Tes 27			1 ☐ Yes		Specify:	, 1 00110	1110411, 0.0.7	Specify		etc.
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21215-0036	na In	Completed		ecedent's Edu ly highest grad			16a. Dece	dent's Usu kind of wo DO NOT u	rk done d	lurina most	of worki	ng	16b. Kind of Bu	siness/In	dustry
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9	filled Hygi ther	ပိ	8 Years 17. Father's Name (First,	Middle, Last)			Ma	Curue	: Ope			(First, Middle, I			nuracture
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Z	d 2 should the and Me	F	19a. Informant's Name/R			iece	19b. Mailir	a Address	(Street a			l Route Number	City or Town	State Zir	Code)
Maryland	42 a 7		Mrs. Cher									Maryla			, 6000,
ē,	Tea tha		20a. Method of Dispositio				Place of Dispo	sition (Na	ne of	1	D	ate	20c. Location -	City or To	own, State
Baltimore,	Pages ment of I ant: if its ury or o		Burial 2 Cre			110	cemetery, crer Ny Ros	-	-	1	/17/	2006	Baltim	ore.	Maryland
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ñ	Departr Imports any inj		1)0	•	. (11.	.06						ome of			
	\$ **		23a. Part1. Enter the dis	ease, or compli	ications that caus	sed the dea	th. Do not ent	er the mod	le of dying	g, such as o	cardiac o	r respiratory arre	est,		Approximate
	Physician		Immediate Cause (Final	re. List only or	19 cause on each	n line.		2-	E0.	/ 2	7/0	EACE			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)			ONA)				1	יכקו	-1134			
	Examiner				Call	EST.	THE	HE	AR	7	F-A	ILUR	E		
3.7	* 44	Jer	Sequentially list condition if any, leading to immedia	is, ate	Due to (or								~		
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1	CERE	-BR	OVAS	Cell	AR	A	w	D ENT	_		
oʻ	be executed iclen and burial-transit	Ë	resulting in death) Last		Due to (or	as a consec	quence of):								
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9	death certifica e ettending ph d for use as th	Physician/Med	IF FEMALE:												
Вох	eath certifi ettending I for use as	an/l	23b. Was decedent pregrin the past 12 month	Iditi	3c. If yes, outcor 1 ☐ Live birth			Ectopic pr	egnancy				23d. Date		*
		sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	15 /	4 Pregnant 9 Unknown		death 5	Other (sp	ecify)				Mon	tn	Day Year
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ls,	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant	conditions cor	induting to death	n but not res	suiting in the ur	iderlying c	ause give	n in Part I.					ne cause of death?
orc	w require been sig should b	ted										1 L Ye	s 2 No	3 Prob	ably 4 Mknown
Records,	e law has b	Completed										24a. Was ar autops			psy findings available impletion of cause of
	Thate are	Co										perform 1 ☐ Yes 2	led? de	eath?	2[] No
Vita	Attending Physician: r death. sctor: After this certific. by the funeral director,	Be	25. Was case referred to examiner?	_	11-1						eath	Check only one	J		
o	Physic this c	၉	1 ☐ Yes 2 ♠ No		lospital:		ER/Outpatien			4 Privur		ne 5 Reside			v)
ŭ	ling F	on:	27. Manne of Death 1 atural 5	Pending	28a. Date of II (Month, I	njury Day Year)	28b. Time of Injury		Bc. Injury Work	?		8d. Describe ho	w injury occurre	d	
Sic	death ctor: /	cat	2 Accident 3 Suicide 6	Could not be				М		es 2 □ N			-		
Division	or At	Certification:	4 Homicide	determined	28e. Place of building,	Injury - At h etc. (Speci	ome, farm, stre fy)	et, factory	, office		2	Bf. Location (Str. City or Town,	eet and Numbe State)	r or Rura	l Route Number,
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	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 (Check only 2 None)	ertifying Phys ledical Examir	icien: To the be	st of my kno of examina	owledge, death ation and/or inv	occurred estigation	at the time , in my op	e, date and inion, death	l place, a h occurre	nd due to the ca id at the time, da	use(s) and man te and place, ar	ner as st nd due to	ated. the cause(s)
	thin i	Mec	29b. Signature and title of		and manner	Stated.			: License			-,	d. Date signed		
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	10		30. Name and address of	person who co	mpleted cause o	or death (Iter	п 23a) (Туре, I	rint)	PL		12	inda	111 1	, ^	7.220
1	Sta	te.	31. Date filed (Month Da)	Year)	32 Regi	strar's Signa	ature 8	1	1100	.0	00	mycel	IC W)	41266
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			For State Registrar	State of Maryla		artment of Hertificate of E		ental Hygie	ZHHb	01003		
		3	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	of Death 3. Time of Death			
	Physici /Medio		HELEN F	ITTS				01 1	5 200	6 335 PM		
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				CAL CENT	ER	BALTIM If Under 1 Year			~	OLE CITY		
*	Funeral Director		5. Social Security Number 6. Se	X 7. Age (in yrs	s. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye	ear) C	thplace (State or Foreign ountry)		
			220-34-1762 Usual Residence of Decedent		7.7			APR. 4 19	28 MA	RYLAND		
	yland		10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits		
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	h the	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?		
	within 72 hours after death with the Maryland ane. then "naturel", or Items 23s or 28s-f ehow ha Mudical Evartiner mark be motified at		1200 HANSWORTH P	L APT I		2]	L221		U.S.A.			
	dea me	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe	offy Yes or No-	14. Race - Am Black, Whi			
98	or It	F	1 Never Married 2 Marned	1 ☐ Yes 2 ZNo If Yes, Give	1	1 ☐ Yes 2 ☒ No		noun, oto.,	Specify: BL			
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an	d be ental ced o	To Be	DAN REED					COOPER	,			
2	should ind Men marke umatic	F	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailii	ng Address (Street a.			ity or Town, State.	Zip Code)		
Ž	and 2:		Velma Cooper/Daug	hter) Hanswort						
ē,	uges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 Is marked other then "naturel", or Items 23s or 28s-f show or other traumatic event, the Medical Examinatinal traumatic event, the Medical Examinatinal traumatics.		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of matory or other place	D		Location - City or			
ě.	Pages nent of int: If It iry or o		1 🖾 Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify		ARRISON		01-2	1-06 01	TNCC MIT	LS, MARYLAND		
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/	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):							
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Box	eath certifi attending I for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	tal death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year		
	that the deatt ed by the atte detached for	Physician/Me	1 ☐ Yes 2 No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	death 5	Other (specify)				,		
P.O.	that the by detac	P	Part II. Other significant conditions co	ontributing to death but not re	esulting in the u	nderlying cause give	n in Part I.	23e. Did tobac	co use contribute t	o the cause of death?		
ds,	signed be de	d by	HUPTERTENS	_	-	, and a second great		1 □ Yes	_	robably 4 Unknown		
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a				21LLATION	1		-	1 Yes 21		s 200 No		
5	Physician: r this certific ral director,	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: V.	758 0	ot all DOA Othe	26. Place of Death					
Division of Vital Records,	Phy r this sral d	To It	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	☐ ER/Outpatier 28b. Time o	11 30 00A	4 INUISING HON	8d. Describe how	e 6 Other (Spe	ecify)		
on	Attanding r death.	it lo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work	? 'es 2 □No		,			
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ā	al or	Certification;	4 Homicide	building, etc. (Spe	city)			City or Town, S	state)			
	To the Hospital or Attanding Physician: within 24 hours effer death. To the Funeral Director: After this certilic completely filled in by the funeral director.	edical (29a. Certifier Certifying Phy (Check only one) 2 Medical Exam	/sician: To the best of my k iner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the tim vestigation, in my op	e, date and place, a inion, death occurre	and due to the caused at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)		
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	1		30. Name and address of person who d	completed care of de th (It	em 23a) (Type		10000		011131	2006		
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ORIGINAL

Direction The control of the cont	0000	ental Hygiene Rag. No? ()	01004									
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Social Security Number Social Security Num		nd Be										
10.5 Size 10.5 County 10) 0	(Month, Day, Year)	Birthplace (State or Foreign Country) ORTH CAROLINA									
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25. Was case referred to medical examiner?	2 □ No 3 □ F	1 ☐ Yes 2 ☐ No	Probably 4 Unknown									
25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 Natural 2 Accident 3 DOA 28c. Injury at 28d. Describe how injury occurred 1 Yes 2 No 28d. Describe how injury occurred 1 Yes 2 No 1 Yes 2 No 28d. Describe how injury occurred 1 Yes 2 No 1 Yes 2 No 28d. Describe how injury occurred 1 Yes 2 No 1	prior to	autopsy performed?	e autopsy findings available to completion of cause of h? Yes 2 No									
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building, etc. (Specify) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and dides of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			Specify)									
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	16)	City or Town, State)										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ind place, and di	ed at the time, date and place	due to the cause(s)									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Poles T. Laurdon M. D. 4940 Eastern Avenue A1 East, Baltimore, Maryland	nuary	Januar	18, 2006									
	Marylan	Baltimore, Mar	d 21224									
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature												

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		-	. FOI	State of Maryland	•				21116	01005			
			State Registrar Amend item # 1. Decedent's Name (First, Middle, Last)	5 Per FH G*52	2/10	70003H 011		2. Date of Death Month		3. Time of Death			
	Physicia /Medic		ANGELA MATTIN	IGLY PHILLIPS	<u> </u>			JANUARY	17, 2006	7:00 PM			
	Examin	er	4a. Facility Name (If not institution, give str Saint Joseph M	edical Cent			TOWS	on	4c. County of Death Baltimore				
	Funeral Director		5. Social Security August 6. Sex 1 1 1	7. Age (In yrs. In	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day, Y	1914 Mary	place (State or Foreign ntry) land			
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits			
	e Mary	ctor	Maryland Baltimore	Timo	onium					1 ☐ Yes 2 ☐ No			
	th with th	ai Dire	10e. Street and Number 2300 Dulaney Valley	Road K308		10f. Zip Code 21093	3	100	g. Citizen of What Country? USA				
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Depertment of Heelth and Mental Hygiene. Important: if Itam 27 is marked other then "natural", or Itams 23a or 28a-f show important: if Itam 27 is marked other then "satural", or Itams 1 and 1	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married XX Wildowed 4 Oivorced	2. Was Decedent Ever in U.s Armed Forces? 1 ☐ Yes \(\foldar{1} \) No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes XX☐ No	lispa <i>n</i> ic Origin? (S an, Mexican, Puer Specify:	specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.			
2-0	72 ho	eted	15. Decedent's Educa (Specify only highest grade	ation completed)	16a. Deced	dent's Usual Occup	ation during most of wo	rking 16	6b. Kind of Business/l	ndustry			
121	within ene. then '	Jupi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	kind of work done DO NOT use retired Secretary	7		Legal				
ק סר	e filed Il Hygi other	Se C	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, Ma	aiden Sumame)				
ylar	Menta Menta arked	To Be	Howard Thomas Matti					ne Shepp					
Maryland 21215-0036	d 2 sh th and th and 7 ie m traum		Jean Phillips Brune					ural Route Number, on, Maryla	City or Town, State, Z and 21286	ip Code)			
re,	s 1 and Heel	1	20a. Method of Disposition	20b. P	line and	sition (Name of matory or other place		15 Jan 19	0c. Location - City or 1	own, State			
<u>im</u>	Page ment c ant: If ury or		1)\(\infty\)\(\mathbb{B}\)\(\mathbb{U}\)\(\mathbb{B}\)\(\mathbb{U}\)\(\mathbb{I}\)\(\mathbb{D}\)\(\		0/06 Baltimore, Marylan								
Baltimore,	permit. Depertiumport. eny inj		21 Signature of Funeral Service Licenses White Styling		efeld Funeral timore, Mary	A TOTAL STORY OF THE PARTY OF T							
	st,	Approximate Interval Between Onset and Death											
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9	ing ph	9	IF FEMALE:	10.00									
.O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of di 9 ☐ Unknown	death 3	Ectopic pregnanc Other (specify)	у		23d. Date of deli Month	very Day Year			
Δ.	es that igned b be deta	þ	Part II. Other significant conditions conf	ributing to death but not res	ulting in the u	ndertying cause gr	ven in Part I.		acco use contribute to				
ord	v requir been s should	eted						1 Yes					
Records,	The law	Completed						24a. Was an autopsy perform	prior to d	topsy findings available completion of cause of			
Vital		BeC	25. Was case referred to medical examiner?					eath (Check only one					
€	Phys this aldii	ို	1 ☐ Yes 2 No Ho	ospital: 1 Inpatient 2 28a. Oate of Injury	ER/Outpatie	IL 3LI DOA		Home 5 Resider	nce 6 Other (Spec	eify)			
on	ding After fune	ation	1 XNatural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wo	rk?`]Yes 2∐No	200. 2000130 110	windary occurred				
27. Manner of Death 1									eet and Number or Ru , State)	ral Route Number,			
	To the Hospital or Attenwihin 24 hours efter deatl To the Funeral Director:	edicai C		rician: To the best of my knoter: On the basis of examina and manner stated.									
	To the within 2 To the complet	Me	29b. Signature and title of certifier	2. A.A. N		29c. Licens	se number		d. Date signed (Monti	/			
	1/			ou, M.D	•		17695	U	anuary	17,2006			
	12		30. Name and address of person who co				IVE TOW	SUN MUD	/LAND 212	- ι7ιΔ.			
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa		JLEN DR	4 Jun 1 Jun VV	MAIN PIPEL	LETINI/ EIE	1/2 mg.			
Registrar JAN 1 9 2006													

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ORIGINAL

		1 - For State Registrar	State of Maryland	•		t of Hea e of De			Re	g. No.	006	010	06
Physic		1. Decedent's Name (First, Middle, Last Dorothy R. Perry						M	ate of Death onth Nuary	Day	Year 2006	3. Time of 0	Death A _M
/Med Exam		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or Loc	ation of Death			T	ounty of Death		
Funera Directo		402-10-3444		ast birthday) Yrs.	If Under Months	1 Year If I	rna Pa Inder 24 Hrs. ours Min.	ark 8. De Sej	ate of Birth Jonth, Day, P • 25	Year) 19	Anne Anne Anne Anne Anne Anne Anne Anne	undel place (State or intry) ginia	Foreign
death with the Maryland ms 23a or 28e-f show r must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County	imore 10c. City	, Town or Lo	cation Lansd	lowne						10d. Inside City 1 ☐ Yes	
with the a or 28e be notil	Director	10e. Street and Number 240 Laverne Avenu	0		10f. Zip	Code 212	27		10	•	en of What Cou	,	**
eath ns 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S	S. 13.	Was Dece	dent of Hispar cify Cuban, N		pecify Y	es or No-		ted Sta		
<u> </u>	₽ S	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 24 No If Yes, Give Year or Dates:	i	If Yes, spe	77	exican, Puert pecify:	to Rican	, etc.)	s	Black, White Specify: V	, etc. Thite	
within 72 hours aften. When maturel, or the Males I and the maturel or the Males I and the Ma	Completed	15. Decedent's Edi (Specify only highest grad	cation (e completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	al Occupation ork done durin se retired)	g most of wor	rking	1		of Business/I r Lower	-	
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VIANG 2 buid be filed Mental Hygin arked other atic event, I	Be	17. Father's Name (First, Middle, Last)				18.	Mother's Nan				-		
aryle should nd Mer n marke umatic	ြင	Freelin Ramey 19a, Informant's Name/Relationship (T	vpe. Print)	19b. Maili	na Address	(Street and		•	ell Th te Number.		Sbury Town, State, Z	ip Code)	
Z7 is		Patricia Mager, D								-	MD 21		
Baltimore, IM Department of Health Importent: If Itsm 27 I Shay injury or other tre		20a. Method of Disposition	20b. Pl	ace of Dispo	osition (Na	me of		Date			ation - City or		
Pages Pages ment of ent: If It ury or o		1 Burial 2 □ Cremation 3 □ 1 Donation 5 □ Other (Specify)	Men Men	norial	Park		1-18				sville,		
Baltimor permit. Pages Department of I importent: If Its any injury or o		21. Signature of Funeral Service Licente	May April								1 Home,		
		23a. Part1. Enter the disease, or comp	lications that sused the de								owne, M	Approximate	3
Physiciar /Medica Examine		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due to (or as a consequence) Due to (or as a consequence)	ience of):	201	AMO	us CE	EU	CA	of	SKIN	Interval Betwonset and O	
/60, te be executed ysician and te burial-transit	Lcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequ										
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Geath ceri	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	⊒Ectopic p ⊒ Other (s					23	3d. Date of deli Month		/ear
ecords, P.O. law requires that the as been signed by th		Part II. Other significant conditions co	entributing to death but not resu	ulting in the u	underlying (cause given in	Part I.	2		acco us s 2□	e contribute to No 3 ☐ Pro	1.4	eath? Jnknown
age has a	Completed								24a. Was ar autopsy perform	/ !	24b. Were au prior to death?	topsy findings a completion of ca	available ause of
F VITAL Relysicion: The lis certificate his director, page	Be	25. Was case referred to medical examiner?	Hannital.				Place of De						
on of Vital ding Physicien: h. After this certifica funeral director,	lon: To	27. Manner of Peath	Hospital: 1 Inpatient 2 Inpatient 2 (1) 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury		28c. Injury at Work?	Nursing H	_	5 🗌 Reside Describe ho		Other (Spec	ify)	
ision (then ctor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st			2 (110		ocation (Str City or Town		Number or Ru	ral Route Numi	ber,
Div To the Hospitel or A within 24 hours after To the Funerel Dire completely filled in by	Medical C		ysicien: To the best of my kno liner: On the basis of examina and manner stated.)
To the within To the comp	Me	29b. Signature and title of certifier	mile	1	29	D3/	mber 36		29	d. Date	signed (Monti	n, Day, Year)	
11)	30. Name and address of person who	completed cause of death (Item	23a) (Type	Print)	05 K	UBR	-00	E /2	D /	BAUTIL	ward.	1236
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture									

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ODIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** January 18 2006 7:24 A Morton Quill Sr. David /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Laurel Laurel Regional Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1)**€**)KM 2 □ F Yrs. March 21 1944 Maryland Director 220-42-0939 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

other then "naturel," or items 23e or 28e-f ehow 10d. Inside City Limits 10a. State 10c. City, Town or Location in then "naturel", or items 23s or 28e-f ehow 1 Yes 2 No Prince George's Laurel MD Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20707 U.S.A 7301 Brooklyn Bridge Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 MYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 🖾 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Courier Private 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filit Department of Health and Mental Hy important: If Item 27 is marked oth eny injury or other traumatic event Be Elizabeth Phelps John Thomas 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Normandy Park 20858 2nd Place SW, Washington 98166 Stephanie Moss / Daughter Date 20c. Location · City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/20/2006 National Crematory Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Fleck Funeral Home Inc., 7601 Sandy Spring Road Laurel Maryland 20707 Non 2 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1 week Septic Shock /Medical Due to (or as a consequence of) Examiner 1 week Respiratory Failure/ Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed use as the burial-transit Liver Failure / Cirrhosis 1 year Due to (or as a consequence of): attending physicien Physician/Medical Alcoholism years IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No ò 4☐Pregnant at time of death 5 Other (specify) P.O. been signed by the s should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ Records, 3 Probably 4 □Unknown 2 🗆 No 1 X Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an The law page 2 autopsy perform performed? 1 ☐ Yes 2 ☒ No this certificete Vital Physician: 26. Place of Death | Check on y one director 25. Was case referred to medical Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 DOA 1 Yes 2 XNo ို oţ After thi 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: Attending Division 1 X Natural 5 Pending М 1 Yes 2 No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 - Homicide ŏ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the lime, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of contries D39532 January 18, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Timothy McClain MD 321 Prinve George Street. Laurel Maryland 20707 3. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JAN 1 9 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 11 per inf g851 1-26-06 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend Item #23a Per PHY G852 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 1 **Physician** 16 2006 12:45p ^M Frances Robinson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Stella Maris Hospice Timonium Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🖫 F 88 Yrs. Director 219-10-6565 8-19-17 S.C Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location in then "natural", or iteme 23a or 28a-f show the Medical Examiner must be notified at Yes 2 No Director Md. NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2045 Kennedy Avenue 21218 death USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Black Specify: Be Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Seamstress 6th grade Factory or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Artimus Baxter Lugenia Stokes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 leany injury or other traisone. Catherine Cooper Sister 6204 Gist Avenue, Baltimore, Md. 21215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Md. Nat. Mem. Pk. 1-23-06 Laurel, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 lady wan March F.H. East 1101 E. North Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** ALZHEIMER'S DEMENTIA Pnuemonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit end Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical ate has been signed by the attending phys page 2 should be detached for use as the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **K** No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2X No Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{X} \) Other (Specify) \(\text{HOSPICE} \) 4 hours after deam.
Funeral Director; After this c ို 1 ☐ Yes 2 X No ŏ 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Attending Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined To the Hospitel or Attervision 24 hours atter de To the Funeral Directo completely filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 117/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Sparke JAN 1 9 2006

		-	amend #8 Per File 6884 Vol. 1 Popartment of Health and Mental Hygiene 1 - State Registramend Item #24a Per Phy g851 Project Death Reg. No. 0 6 0 0 0 0
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ter death	or Items 23 imber must	by Funeral Director	11. Marital Status 12. Was Decedent See in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 4 Divorced 4 Divorced 5 Divorced
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Baltimore	Department Important: any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23. Name and Address of Facility Bradley - Ashton Funeral Home, P. A 21.34 Willow Spr. N. g. 2d. 21222
	ysician Wedical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):
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Division of Vital Records, or Attending Physicien: The law requires t	After this funeral di	P	examinar? 1
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To the Hos	within 24 h To the Fut completely	Medical	(Check only one) Medical Examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	Sta	te ar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Walid Barbour 9000 Flanklin Square Drive Baltimore, MD 2123; 31. Date filled (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

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and 2	f Health and Mental Hygiene. item 27 is marked other than "neturel", or Items 23s or 28e-f show other treumatic event, I'm Medical Exactiner must be notified at		Ronald Surgu	y / Son		7 10th St	100.00		a, MD 2	1122
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1)		30. Name and address of person	licks 14 M	P, 301	Wospital	Prive, 5	17400	avnie, 11,	2100
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Noah Smith 06-0427 AKG

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23a, 27, pen/E, 2853, 3/30/16 TI State of Maryland / Department of Health and Mental Hygiene () () () Unpend item#

1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Noah Loque Smith Jan<u>uary</u> 17, 2006 8:31 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | ff Under 24 Hrs.

Months Days Hours Min.

3 1 1 8. Date of Birth (Month, Day Year) 10/06/2005 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 1 M 2 □ F Months 3 218-73-3471 Director MD Usual Residence of Decedent the Maryland worde I 10a State 10c. City, Town or Location 10d. Inside City Limits Ith and Mental Hygiene. 27 ie marked other then "naturel", or iteme 23a or 28a-1 ehov treumatic event, itse Medical Examinar must be nodited at 1 ☐ Yes 2X No Director MD Anne Arundel Pasadena 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code filed within 72 hours after deeth with 7864 Red Lion Way 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritaf Status 1 ☐ Yes 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Yes, Give Completed by Year or Dates: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 Infant Infant permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy importent: if item 27 is marked othe eny injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jason Christopher Smith Desiree Ann Miller ၉ 19a. Informant's Name/Refationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jason C. Smith / Father 7864 Red Lion Way, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem Pk 01/20/06 Glen Burnie, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 21. Signature of Furgerat Service-Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** Incipient meningitis complicating upper respiratory infection /Medical Due to (or as a consequence of): Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical fF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 5 Other (specify) ed by the 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 Probably 4 Unknown 1 Tyes Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of deal ?

1 Yes 2 No 1D Yes 2 ☐ No 25. Was case referred to medical 26. Pface of Death | Check only one) examiner Hospitaf: 1 | Inpatient | 2 | TER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1X Yes 2 No in: 28a. Date of Injury (Month, Day Year) 28c. fnjury at Work? 27. Manner of Death Certification; 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1X Naturaf 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation efter death Director: 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funerei (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Windical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Greck only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) Ja4 O.C.M.E. MD January 18, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore Maryland 7 Greenber M O V 32 Régistrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 9 2006 Registrar

Linda Springrose Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-00439 NJM State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** J. Springrose Linda January 2006 0046 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
Months | Days | Hours | Min. | 5-27-1968 n/a Mercy Hospital 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F 491-88-3567 Missouri Director Usual Residence of Decedent deeth with the Maryland permit. Pages 1 and 2 should be filed within 72 hours eiter deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or iteme 23a or 28e-f show warly injury or other traumatic event, the Madical Examinant be publified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Directo Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Charles Plaza #2403 21201 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 € Never Married 2 Married 1 ☐ Yes 2√ No If Yes, Give A Baltimore, Maryland 21215-0036 1 Yes 2 No ۵ Specify Specify: White 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12years College (1-4or 5+) years Attorney Law Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Springrose Jane Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Springrose (Mother) 607 Orlando Ave. Bradenton, FL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4 Donation Bayview Crematory 1-19-2006 Baltimore, Maryland 21. Signifure of Fundral Service I insee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 130 E. Fort Ave. Baltimore, MD 21230 J. Wayne Osterling and 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or bear failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pulmonary thromboembolisus Due to (or as a consequence of): /Medical Examiner Deen venou. vehous Thrombosis Sequentially list conditions, I ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit happy leg fineture or Attending Physicien: The law requires that the death certificate be execu Due to (or a consequence of): Box 68760. by Physician/Medical use es the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy igned by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 ☐ Probably 4 Di€nknown Be Completed page 2 should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? hes 2□ No Division of Vital 1 Xes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: XX Yes 2 □ No 1 Inpatient 2 R/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification; 1 Natural 5 Pending Injury 1 ☐ Yes 2 🗖 No 2 Accident
3 Suicide investigation the unhon 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) undio unhur

efter death. filled in by Hospital within 24 hours e To the Funeral D completely To the

0

Medical

(Check only one)

29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

touchd



who completed cau o death (Item 23a) (Type, Print)

111 Penn Street

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

OCME

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21201

January, 18, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No... 2 Date of Death 1. Decedent's Name (First, Middle, Last) SMITH ANUARY 15, 2006 16=06 りゅんり エサイ 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) HAUREDE GLACE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Hours | Min. | (Month, Day, Year) HARFOND MEMORIAL HOSPITAL HARFOND 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 1□M XXIF 61 OCT 25 FLORIDA 199-34-6874 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ty∑Yes 2 No PENNSYLVANIA PHILADELPHIA N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3919 PENNSGROVE STREET 19104 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade PARC COORDINATOR CHILDRENS HOSPITAL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) CARLIE LITTLE ELLA WOODS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 718 C ST N.E. WASHINGTON, D.C. Dare L. Johnson 20002 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State Date 20a. Method of Disposition 1 □ Burial 2X Tremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) IVY HILL CEM. 01-21-06 PHILADELPHIA, PA., 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 21. Signal e of Funeral Service Licenspe 231. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HASCUD Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 N = 0 24a. Was an autopsy performed? 2 0 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 Pr/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) ¥ Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of

Examiner burial-transit Box 68760 ÷ use as t signed by the er o. Records, P. certificate Vital or Attending Physician: ð After thi Division death. Director: ,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

23a or

6

'natural'

the Medical Examiner must be notified at

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Completed

Be

death with the Maryland

filed within 72 hours after

Pages 1 and 2 should be fill ment of Health and Mental Hillant: If itsm 27 is marked other.

5

Department of important: if sny injury or once.

Physician

/Medical

Baltimore, Maryland 21215-0036

Examiner Completed by Physician/Medical Be ٩ Certification:

27. Manner of Death 1 Natural 5 Pending 2 Accident

29a Conflien

6 Could not be 3 Suicide 4 Thomicide

31. Date filed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death construct at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

JANVANY 15, 2006

M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2336 YORK NO TIMONIUM MD 21093.

1 ☐ Yes 2 ☐ No

D 21809

State Registrar

7

SPRABHUMD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

hours after To the Hospitel within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 6:15 PM Mary Agnes Shamer IAN 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ST AGNES HOSPITAL BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 3-29-1922 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 25XF Yrs. 83 213-14-2615 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow MD 1 ☐ Yes 2 ➡ No Baltimore Baltimore Highlands Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2843 Tennessee Avenue 21227 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental H is marked of Stanislaus Sylvester Mary Sudlecka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other trau Raymond M. Shamer, Jr./Son 7958 Farmingdale Ct. Pasadena MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place)
Loudon Park Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 122 Burial 2 ☐ Cremation 3 ☐ Removal from State 1-17-2006 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ambrose Funeral Home, 21. Signatur of Funeral Service Licensee Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) troke Physician /Medical tu condevasala Dife Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physicien and for use as the burial-transk certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has lirector, page 2 s autopsy performed' 2 No 2 1 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 LNo funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 Hatural death. M 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: / completely filled in by the f 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide

To the Hospital

Division of Vital Records, P.O.

SHAM

Maryland 21215-0036

Baltimore,

31. Date filed (Month, Day, Year) JAN 1 9 2006

29b. Signature and title of certifier

2801 Foster be Belo WIIIIAMS MT 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

	•	For State Registrar		State	of Ma	ryland /	-			ealth a D <i>eath</i>	ind M	ental Hy	giene Reg. No.	006	01016	
Physici /Medic		1. Decedent's Name (First, Mid VALARIE		WET	T-	- M	ILL	ER				2. Date of De Month	ath Day	Year	3. Time of Death 7:20 PM	
Examin		4a. Fecility Name (If not institute	on, give	street and nu	ımber)	SP		4b. City,		Location of	f Death			County of Deeth	ORE	
Funeral Director		5, Social Security Number 216–62–6553	6. Se			(In yrs. last	birthday) Yrs.	If Under Months		If Under a		8. Date of Bir (Month, Da 1-19-	th		place (State or Foreign htry) Md.	
aryland •how	or	Usuel Residence of Decedent 10a. State 10b. Coun Md •	•	JA		10c. City, To		ation						1	l0d. Inside City Limits	
3e or 28a-	I Director	10e. Street and Number 404 N. Aisqu				Apt.		10f. Zip		2			10g. Citiz	zen of What Cour		
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "naturel", or iteme 23e or 28e-f ehow eumatic event, the Medical Exemitor must be notified at	by Funeral	11. Marital Status 1 Never Married 2 M. 3 Widowed 4 Divorce	arried	12. Was Dec Armed F	orces?	ver in U.S.	13. V	Vas Dece	lent of Hi cify Cuba	spanic Orig	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)		14. Race - Americ Black, White, Specify: B		
within 72 hou ane. Ihan "nature a Madical E	Completed	15. Deced (Specify only high Elementary/Secondary (0-12	ent's Ed	ucation de completed College				kind of wo OO NOT u	rk doné d se retired	turing most)	of working	ng		nd of Business/In	dustry	
ald be filed whental Hygierked other tic event, it	To Be Co	12th grade 17. Father's Name (First, Middle Melvin	e, Last)			Swe		sekee	ping	18. Mothe	rs Name ine	(First, Middle,		Day's Inn den Sumame) Reeder		
ges 1 and 2 should it of Health and Men if Item 27 is marks or other treumatic		19a. Informant's Name/Relatio Kennard Lee	nship <i>(T</i>	уре, Print) Son			12	236 W	alke		e., B	altimo	ce, N		239	
Pa mer ant ury		20a. Method of Disposition 1 ▼Burial 2 □ Crematio 1 □ Other	(Specify)	State	ceme	of Dispose etery, crem	e Cen	_{ther plac} ieter	У	1-21		Re:	cation - City or To istersto	wn, Md.	
permit. Departimont Import		21. Signature of Funeral Service	e Licer	May 1						s of Facilit				nore, Md North Av		
Physician pe executed attending physician and attending physician and tor use as the burial-transit	dical Examiner	23a. Fart1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	or complist only of	a. Due to	o (or as a	consequent	ce of):	N Sel	e of dying	,	cardiac o	respiratory a	rrest,		Approximate Interval Between Onset and Death	
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ♣ No 9 □ Unknown			birth 2 nant at t	f pregnancy : Fetel de ime of death	ath 3	Ectopic pr Other (sp					2	23d. Date of delive Month	ery Day Year	
equires that en signed by ould be deta	by	Part II. Other significant cond			death bu	t not resultin	ng in the ur	aderlying c	ause give	en in Part I.		23e. Did t			he cause of death?	
ticlan: The law recentilicate has be	Completed											24a. Was auto perfo 1 Yes		24b. Were auto prior to co death? 1 \(\subseteq \text{Yes}	psy findings available impletion of cause of	
Physician: r this certifica ral director, i	o Be	25. Was case referred to medi examiner? 1 25. Yes 2 No	-	Hospital:	npatien	t 2 🗆 EB	/Outpatien	t 3□ D0	Othe	26		(Check only o		5 □Other (Specif		
anding Phy lath. or: After this	-	27. Manner of Death 1 Natural 5 Pen 2 Accident inve	stigation	28a. Date (Mo		28	b. Time of Injury		8c. Injury		2	8d. Describe			у)	
To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	4 Horricide	mined	buil	ding, etc.	ry - At home (Specify)						City or To	wn, State,			
the Hosp in 24 hou the Fune inpletely for	fedical	29a. Certifier 1 Certification (Uneck only one) 1 Medic	ying Ph ai Exam	ysician: To the niner: On the and ma	basis of conner state	f my knowle examination ed.	dge, death and/or inv	occurred	at the tim , in my of	ne, date an pinion, dea	d place, a th occurre	ind due to the ed at the time,	cause(s) date and	and manner as s place, and due to	tated. o the cause(s)	
with Von	×	29b. Sispature and Mile of cert 30. Name and address of pers	on who	completed car	MD use of de	ath (Item 23	a) (Type,	Print)) 00	53	723	, CP	JA	e signed (Month,	tated. o the cause(s) Day, Year) Z006	
Sta	ate	JEFFREY 3	r. P./	LL IN	Registra	G00 r's Signature	DS	AM.	1RI	TAN	HO	34,	13 11	TIMOI	Ro	
Regist		JAN 1	500	16	SELE.	, A.	Gal	Mes!								

Second processes Second proc	006 01017		
Second Security Name of floor installation of the street and numbers 2.11 Church Street 8.6 Early 1.00 Early 1.0	4, 2006 3:00 A M		
Physician Phys	nne Arundel		
Temporal Part Temporal Par	9. Birthplace (State or Foreign Country) 919 Maryland 10d. Inside City Limits		
Temporal Part Temporal Par	1 ☐ Yes 2 🖾 No g. Citizen of What Country?		
Temporal Part Temporal Par	.S. Race - American Indian. Black, White, etc. pecify: White		
Physician Medical Examiner Population Physician Medical Examiner Physician Medical Examiner Population Physician Medical Examiner Population Physician Medical Examiner Population Physician Medical Physician Medical Medic	of Business/Industry of Transportatio		
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FFEMALE: 23c. If yes, outcome of pregnancy 23d. Date More 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date More 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy More 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy More 23b. Date 23d. Date 2	Approximate Interval Between Onset and Death		
25. Was case referred to medical examiner? 1	d. Date of delivery Month Day Year		
25. Was case referred to medical examiner? 1	contribute to the cause of death?		
So Was case referred to medical examiner? So Was case referred to medical examiner? So Was case referred to medical examiner. So Was case referred	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No		
So to the second of the second			
29a. Certifier Continue Cont	lumber or Rural Route Number,		
one) and manner stated. 29b Signature and title of certifier 29c License number 29d Date signed	ace, and due to the cause(s)		
	29d. Date signed (Month, Day, Year) Jun war y 16; 2006		
State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christopher albaria 37 & mountain Rd Pasadera M 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Md. ZIIZZ		

			For State Registrar	State of Maryland		artment of H tificate of L		Reg	ne 0 0	6 01018
4	Physicia /Medic		1. Decedent's Name (First, Middle, Las PHERN MC	DOWELL	STF	SONG		2. Date of Death Month JANUARY	Day Ye	3. Time of Death
	Examin		4a. Facility Name (If not institution, give HARBOR HOSP) 5. Social Security Number 6. Se	TAL CENTE		4b. City, Town, or BALT	Location of Death MORE If Under 24 Hrs.	8. Date of Birth	4c. County of I	
IF y	Funeral Director	in		□M 280F 98	Yrs.	Months Days	Hours Min.	April 3,	(ear)	Country) laryland
	e-f show	ctor	10a. State 10b. County Maryland Anne Ar		. Town or Lo 1en Bu					10d. Inside City Limits 1 ☐ Yes 24☐ No
	th with the 23a or 28 Ist be no	al Dire	10e. Street and Number 6670 Shelly Roa	ad Apt. 3A		10f. Zip Code 210	60	100	U.S.	it Country?
036	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28e-f show the Modical Examiner must be motified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2€ No		pecify Yes or No- Rican, etc.)		American Indian, White, etc. White
21215-0036	within 72 hou ane. than "nature he Wedical E	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12th	de completed) College (1-4or 5+)	(Give life. L	dent's Usual Occupa kind of work done o DO NOT use retired maker	ation during most of work)	king	Own Ho	
land 2	uld be filed fental Hygie rked other ilc event, II	To Be Co	17. Father's Name (First, Middle, Last)	Mangum	Trome		_	Grimes		
e, Maryland	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show amy injury or other treumatic event, the Madeal Examinat must be multiled at ance.		19a. Informant's Name/Relationship (1) Sadie Gable / Da 20a. Method of Disposition	ughter 206.P	600	Bartell A	venue	ra <i>l Route Number,</i> Linthicum Date 20	, Maryla	
Baltimore,	artment of ortant: If it injury or c		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	Bay	view C	natory`or other plac Crematory 2. Name and Addres	1/18/			e, Maryland
Ba	Depa Impo any is		23a. part 1. Enter the disease, of com shock, or heart failure. List only	nomuauce	1 40	001 Ritch	ie Highwa	ay Balti	nore. Ma	ryland 21225 Approximate Interval Between
8760,	Physician and // // // // // // // // // // // // //	Ilcal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Onset and Death TWO HONT H S					
.O. Box 6	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2√2 No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of di	Ideath 3[□Ectopic pregnancy □ Other (specify)			23d. Date of Month	
<u>α</u>	The law requires that the ste has been signed by th bage 2 should be detache	þ	Part II. Other significant conditions of	contributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.			ute to the cause of death?
Vital Records,		Completed						24a. Was an autopsy perform 1 Yes 2	ed2 prid	re autopsy findings available or to completion of cause of th? Yes 2 No
Vita	Physician: 'this certifica	o Be	25. Was case referred to medical examiner?	Hospital:	ER/Outpatier	oth Oth	00	ith <i>(Check only one</i> lome 5 ☐ Resider		(Specific)
o	ding P. After fune	-	27. Manner of Death Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	1 28c. Injur	4 Nuising n	28d. Describe how		
Division	in the	Certification:	3 Suicide 6 Could not be determined		ome, farm, st	reet, factory, office		28f. Location (Str. City or Town,		or Rural Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	edicai		nysician: To the best of my kno miner: On the basis of examina and manner stated.						
	To the within 2 To the complete	Me	29b. Signature and title of certifier	o MD		29c. Licens	e number		-	Month, Day, Year)
	3		30. Name and address of person who DR-MAMATHA P	completed cause of death (Iter RABHAKAR, M	n 23a) (Type	Print) 1 , S	. HANOVE	R STR	EET, 1	BALTIMORE
	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 1 9	32. Registrar's Signa						

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State Security of Description Security o		Physici	an	Decedent's Nam	e (First, Middle, Last)							M	onth	Day Year	3. Time of Death
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Physician Medical Examiner Sequentially is conditions contributed to general page of the	n	40 E E a		m	nony	Con	nel	lig	<u>7110</u>	Soll	ers Poi	int Ro	ad, D	undalk,MD.	21222
Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury) resulting in death). Last Disease of control of the property of the prop	10 m			Immediate Cause disease or condition	(Final on	ne cause on each	ed the dear line.	th. (Do)not ent	er the mo	e (g, such as card	diac or resp	iratory arres	t,	Interval Between
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Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of the time of time			5	Sequentially list co	onditions, t		S 3 cored	uence of):	nco	n					
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State The Control of the Control	'n	execu n and ial-tra	Exa	resulting in death)	Last (Due to (or a	is a consec	quence of):							
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State		ignec bed	by	Part II. Other sign:	ificant conditions cor	ntributing to death	but not res	sulting in the u	nderlying	cause give	en in Part I.	2			
State	000	neen s	ted									-	TO GS	2UN0 3UPI	
25. Was case referred to medical examiner? 1	ec	alaw nasb e 2 sl	nple		***							_ 2	autopsy	prior to c	topsy findings available ompletion of cause of
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29a. Certiflier (Chock only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	2	in the	ert	4 🗌 Homicide	Gotommed	building,	etc. (Speci	fy)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		С	ity or Town,	State)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Scalia a801 Hudson Street, Baltimore, Ind 21224 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Hospit 24 hours Funeral letely fille		(Uneck only	Certifying Physical Exami	ner: On the basis	of examina	owledge, deat ation and/or in	h occurre vestigatio	d at the tim in, in my of	e, date and pla pinion, death of	ace, and du ccurred at t	ue to the cau the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr Scalia a801 Hudson Street, Baltimore, Ind 21224 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		To the withir To the comp	Me	29b. Signature and	d title of certifier				2	9c. License	number		290	d. Date signed (Month	, Day, Year)
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	24			31. Date filed (Mo.		. 67	strar's Sign	ature	Cores	1					

			For State	State of Ma	ryland / I		tment of H <i>ificate of L</i>		ental Hy	giene	005	01000
	7-		Registrar 1. Decedent's Name (First, Middle, Last	st)		Cert	ilicate of L	Jealii	2. Date of De	Reg. No. 🦾	006	3. Time of Death
	Physici				ON III				Month Januar	Day	Year 2006	1015a ^M
	/Medic Examir		4a. Facility Name (If not institution, give		711 111		4b. City, Town, or	Location of Death	oundar		unty of Death	1013a
A .			FRANKLIN SQUARE	NURSING &	REHAB		BALTIN	MORE			N/A	
	Funeral		Social Security Number 6. S 1	ex 7. Age	(In yrs. last bi		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birthpi Coun	lace (State or Foreign
	Director		215-40-7889 Usual Residence of Decedent		62	Yrs.			AUG 10	1943		CAROLINA
	/land		10a. State 10b. County		10c. City, Tox	vn or Loca	ition				10	Od. Inside City Limits
	Man	ţŏ	MARYLAND N/A	in the state of th	B	ALTI	MORE					1 Yes 2 No
	with the Maryland a or 28a-f ehow be notified at	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Coun	try?
	death with the Maryland ms 23a or 28a-f show		3316 W. BELVE	ERE			212	15		U.	S.A.	
~		Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. W	as Decedent of His	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No Rican, etc.)	- 14.	Race - America Black, White, e	an Indian,
7148	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖔 Divorced	1 ☐ Yes 2 🛣 N If Yes, Give	o		Yes 2X No	Specify:			ecify: BLAC	
10 12 215-003	within 72 hours after ene. than "natural", or its ne Madical Exemina	ed		Year or Dates:	16a	Decede	nt's Usual Occupa	ition			of Business/Ind	
_/ 215	d within 72 h jiene. r than *natu ine Modical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5-		(Give ki	nd of work done d NOT use retired)	furing most of worki	n <i>g</i>	100. Tallo	01 00011033/110	idstry
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(g) E	be filed stal Hygi ed other	Be	17. Father's Name (First, Middle, Last)					18. Mother's Name	(First, Middle	Maiden Sui	mame)	
Naryland		၉	SIMUEL T TYSON J					LACY D				
oob, Mary	12 sh h and 7 is n traun		19a. Informant's Name/Relationship (nd Number or Rura				
20	s 1 and 2 should f Health and Mer tam 27 is marks other traumatic		Simuel T. Tyson 20a. Method of Disposition	Jr./ Fathe	20b. Place o	of Disposi	ion /Name of	edere Ave	., Balt		, Md . , 2	
2 imor	ages ant of it: if it y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific		cemete	ary, crema	tory or other place	9)			•	•
/12/20	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other tra ance.		21. Signature of Funeral Service Licer		MT Z.		Vame and Addres	01-1	8-06	LANSDO	OWNE, M	ARYLAND
_	Depa Impo any ir		Markana (./5		WI	LLIAM C E	BROWN COM RTH AVENU		FUNERA	AL HOME	P.A.
0	15		23a Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused	the death. Do	not enter	the mode of dying	, such as cardiac o	r respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	METAS-	TATIC			CARCINO				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence		1/4 01	-11/20/10	77 71			7 EMPS
ROX	Examiner	L	Sequentially list conditions,	b								
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60	and and al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence	of):						
PIRED 68760,	ficate be execute physicien and sthe burial-trans			d								
1.	tificat ig phy as th	ledical		u								
反 Box	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	clan/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy	3 □ €	ctopic pregnancy			23d.	Date of deliver	ry
	e death he atte	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at t			other (specify)				Month	Day Year
P.O.	hat the de od by the detached	by Physi	9 ☐ Unknown Part II. Other significant conditions c		t not reculting			- i- D- 41	00- 014			
$\gamma S_{0} \lambda \longrightarrow S_{1} M M E L$ ivision of Vital Records,	ires tha signed l	1 by		E124RE				піп Рапі.		obacco use d fes 2□N	/	e cause of death?
7	w require been si should t	ete	20.101.111	01201/00	2/50/	Cpc						
Z L	The lav	ompleted							24a. Was autor perfo		4b. Were autop prior to com death?	sy findings available apletion of cause of
S_iMUE Vital Reco		ပိ	25. Was case referred to medical			-		00 00	1 Yes	2 No		2 🗆 No
Z ×	Physicia this cert al direct	To B	examiner? 1 Yes 2 No	Hospital:	nt 2□ER/Oi	utpatient	3□ DOA Othe	26. Place of Death			Other (Specific	1
- 0	Attending Physician: r death. sctor: After this certification of the funeral director,		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	y 28b.	Time of	28c. Injury Work	at 2	8d. Describe I			/
So ioi	endir eath. or: Af	catle	2 Accident investigation	1		,,		es 2□No				
∑ .≅	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc.	ry - At home, fa . (Specify)	arm, stree	t, factory, office	2	28f. Location (S City or Tox	Street and Ni	umber or Rural	Route Number,
-	Hospitel or 24 hours afte Funerel Dir tely filled in	Ce	29a. Certifier Certifying Ph				1014					
	To the Hospitel or Attending F within 24 hours after death. To the Funarel Director: After completely filled in by the funar.	edical	(Check only one)	ysician: To the best on niner: On the basis of and manner stat	examination ar	e, death o nd/or inve	stigation, in my op	e, date and place, a inion, death occurre	nd due to the od at the time,	cause(s) and date and pia	d manner as sta ce, and due to	ited. the cause(s)
_	within 2 To the comple	Me	29b. Signature)and title of certifier				29c. License	number		29d. Date sj	gned (Month, E	Day, Year)
			Medio JE.	16/20 1	M-D.		D-1	19425		01/1	7/	06
	3		30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, Pr	int)			-/	120	
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		State of Maryland / Department of Health and No. State of Maryland / Department of Health Maryland / Department /		giene 200	6 0102
Physician /Medica	n II -	Decedent's Name (First, Middle, Last) JACQUELINE M. TABAKA a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	2. Date of DeMonth	Day Ye	3. Time of Death
Examine		Bottombre Woshington Medical Center Glan Burni Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	ا	Anne A	Irundel
Director		526-56-9931 1 M 2 F 67 Yrs. Months Days Hours Min. Journal Residence of Decedent	NOV .	19,1938 1	Birthplace (State or Fore Country) NEW HAMPSHIR
death with the Maryland ms 23e or 28a-f show rmust be nutified at	.	0a. State 10b. County 10c. City, Town or Location ARYLAND ANNE ARUNDEL JESSUP			10d. Inside City Lim 1 ☐ Yes 2 🖔 I
th with the 23e or 2	al Dire	1606 COLESBURY PLACE 10f. Zip Code 207 94		10g. Citizen of What UNITED ST	
or Ite	Completed by Funeral Director	1. Marital Status 1. Was Decedent Ever in U.S. Armed Forces? 1. Never Married 2. Married 3. Wildowed 4. Divorced 1. Was Decedent Ever in U.S. Armed Forces? 1. Yes 2. No If Yes, Specify Cuban, Mexican, Puerto If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto If Yes, Give Year or Dates)	pecify Yes or No o Rican, etc.)	Specific	American Indian, White, etc. WHITE
Laryidilid X IX 15-00-50 2 should be filed within 72 hours at and Mental Hygiene. Is marked other then "naturel", or eurnatic event, the Medical Erean TO Be Completed hyst	ompleted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) HOMEMAKER	king	16b. Kind of Busin	
should be filed and Mental Hyg smarked other umatic event,	lo Be C	RALPH PLACE ANNE PA		, Maiden Sumame)	
Mar and 2 sho alth and 127 is m or treum		19a. Informant's Name/Relationship (Type, Print) CAROLYN M. WILSON / DAUGHTER 19b. Mailing Address (Street and Number or Ru 1606 COLESBURY PLACE,			
Datumore, Mary permit. Pages 1 and 2 shou Department of Health and M Importent: if item 27 is mer any injury or other treumat angues.		`4 □ Ponation 5 □ Other (Specify) CEMETER LLE MD VET. 20	Date UARY 18 006		LE, MARYLAN
Deermit Depar Impor any in		22. Name and Address of Facility KIRKLEY—RUDDICK FUL 421 CRAIN HWY., S.	NERAL HO	OME, P.A. N BURNIE,	MD 21061
be executed /Medical Examiner purial-transit	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially at condition for any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	PD		Approximate Interval Between Onset and Death
oo/or	Physician/Medical E	d		23d. Date o Month	f delivery Day Year
wrequires that the de been signed by the should be detached to the control of the	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			te to the cause of death' Probably 4 □Unkno
VICAL HECO sicien: The law re- certificate has bee	Completed		24a. Was autor perfo	ormed? deat	e autopsy findings availar to completion of cause h? Yes 2 No
ovision of vital records, P.O. box or at attending Physicien: The law requires that the death cer after death Director. After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use	ion: To Be	27. Manner of eath 28a. Date of Injury 28b. Time of Injury Work? 28c. Injury at Work?	lome 5 Resi	dence 6 Other (Specify)
Cor Attending afer death. Director: After time by the fune	Certification:	3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (: City or To		or Rural Route Number,
_ 6 5 6 C	- 1	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	, and due to the rred at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)
Union the Hospitel or thin 24 hours after the Funerel Dirempletely filled in	Medical	and manner stated.		29d Date Linned /A	forth Day Year)
he Hosp n 24 hou he Funer pletely fil	2	and manner stated. 29b. Signature and title of certifier 29c. License number MDD00608 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) YNENNATOKICS OMD, BAZTIMORE WASILL	24	29d. Date signed (A	forfith, Day, Year) 2006

		•	For State Registrar	State of	Marylar			nt of H te of L		and Me	•	giene Reg. No.	HHA	01022
100	/sicia		1. Decedent's Name (First, Middle, Last	THANI	EL						2. Date of De Month Januar	Day	Year 2006	3. Time of Death
96 (*) 194 200 (*)	amine	-	4a. Facility Name (If not institution, give University of MARYL 5. Social Security Number 6. Se	AND MEDI	CAL S		Br		Location o	2E		Bx	County of Death	re
Fune Direc				X M 2□F /.	58	last birthday Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da 12–28–	iy, Year)	Cou	place (State or Foreign ntry) RGINIA
faryland show	10 70		10a. State 10b. County MD • N/A			ity, Town or t								10d. Inside City Limits 1 ☑ Yes 2 ☐ No
ith the h	Na notifi	Director	10e. Street and Number	ATTE AT		BALTIM		ip Code	0.1				en of What Cou	21.
.0036 hours after death with the Maryland ture!; or tteme 23e or 28e-f show	DEL COUST	ā	906 PENNSYLVANIA 11. Marital Status	12. Was Decede Armed Force	ent Ever in U	J.S. 13	. Was Dec	212 edent of Hi ecify Cuba		gin? (Spec	cify Yes or No		USA 4. Race - Ameri Black, White	
5-0036 72 hours aft	al Exami	۾	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tes 2 If Yes, Give Year or Date	Λ	162 Doo	1 Yes		Specify:	_		1	Specify: BLA	
within the	DESCRIPTION OF THE PROPERTY OF	Completed	(Specify only highest grad	College (1-4	or 5+)	(Giv	e kind of w	ual Occupa rork done d use retired	luring most	t of workin	9		od of Business/Ir	,
		To Be C	17. Father's Name (First, Middle, Last) WILBUR BROOKS								(First, Middle		Sumame)	
27 E d	er traum		19a. Informant's Name/Relationship (7) MARLYN THANIEL(W.			906	PENNS	YLVAI		VE. A	APT 2B		Town, State, Zij	CODE 21201 MARYLAND
0 0 - 1	-		20a. Method of Disposition 1)	MT MT	Place of Disp cemetery, cri • ZION	ematory`or CEMI	other place		1-19-		BALT		MARYLAND
Balt Permit. Depertri	eny injury o		21. Signature of Fugleral Service Licens Jonatha	JONATH	AN D.								AL HOME E, MARY	, P.A. LAND 21217
Physic	ian		23a. Part1. Entret the disease, or comp shock, of feart failure. List only o Immediate Cause (Final disease or condition	_	sed the dea h line.		nter the mo	de of dying	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
/Medi Examii			resulting in death) Sequentially list conditions,	a	as a consec									
rcuted	ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		as a consec	quence of):								
8760, cate be executed physicien and	the burial	dicai Ex	resulting in death) Last	Due to (or	as a consec	quence of):								
.O. Box 6 the death certification of the attending of	a for use as	cian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outco 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknow	1 2 ☐ Feta t at time of c	al death 3	□Ectopic □ Other (s	pregnancy				2:	3d. Date of deliv Month	ery Day Year
wrequires that been signed b	ulid be deta	ed by Pi	Part II. Other significant conditions co	ntributing to deat			underlying	cause give	en in Part I.		23e. Did t			he cause of death?
	page 2 sn	Completed by Phys					_			_	24a. Was autor perio		24b. Were auto prior to co death? 1 \(\subseteq \text{Yes}	opsy findings available impletion of cause of
Vital	ector	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 1 np	ations 25] ER/Outpatie	ent 3⊡ ⊑	Othe			(Check only o			
JIN C		ation: To	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of (Month,		28b. Time Injury		28c. Injury Work	4 LINU	2	8d. Describe		Other (Special occurred	(y)
Hospitel or Attend 24 hours after death Funeral Director:	Tilled in by in	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	Injury - At h , etc. (Speci	nome, farm, s	treet, facto	ry, office		2	8f. Location (City or To	Street and wn, State)	Number or Run	al Route Number,
Hospi 24 hou		Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	rsician: To the be iner: On the basi and manner	s of examina	owledge, dea ation and/or i	th occurre	d at the tim n, in my op	e, date and pinion, deat	d place, a	nd due to the d at the time,	cause(s) a date and	and manner as s place, and due t	stated. o the cause(s)
To the To the	comp	W	29b. Signature and title of certifier	nP				oc. License		LI 1/-/-			signed (Month,	
761		-	30. Name and address of person who con SIK HUR MD	ompleted cause	of death (Ite	m 23a) (Type	. Print)				MD		iary 14.	2000
The second	Stat gistra		31. Date filed (Month, Day, Year) JAN 1 9 200	324 leg	istrar's Sign	ature	and .	• •	11377	<i>,</i>	ィツ	- 20	-	

		,	For State Registrar	State of Marylar	nd / Depa	artment of H	lealth an		ygiene	nn s	01023
			Hegistrar Decedent's Name (First, Middle, La	st)		tinoate or t	Jean	2. Date of I	Reg. No Death	-000	3. Time of Death
	Physici		T1 0 11	•				Month	Day		8:32 P M
	/Medic		Elmer S. Wynn 4a. Facility Name (If not institution, giv	re street and number)		4b. City, Town, or	Location of D	Onath Ol	1	County of Dea	
	Examin	er	Prince Georges			Chever		Jean		rince G	
	Formul			Sex 7. Age (In yrs.	last birthday)	if Under 1 Year	If Under 24	Hrs. 8. Date of E	lieth	O Pie	thplace (State or Foreign
	Funeral Director			15k ^{M 2□ F} 91	Yrs.	Months Days		Min. (Month,)	Day, Year)	Pen	nsylvania
			Usual Residence of Decedent								, , , , , , , , , , , , , , , , , , , ,
	ylan		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits
	Ma-f-s	Director	MD Prince	Georges C	hever1	У					1 ☑ Yes 2 ☐ No
	or 28	ire	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What C	ountry?
	238 c	ai	6214 Kilmer St	reet		20785			Į	JSA	
	dea	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin	? (Specify Yes or I	10-	14. Race - Ame Black, Whi	
9	or Ite	F.	1 ☐ Never Married 2 ☐ Married	1 Tyes 2 □ No	ĺ	1 Yes 2 No	Specify:	delto i licari, etc.)		Specify: B1	
8	irel',	d by	3 XWidowed 4 □ Divorced	Year or Dates:			Specify.			Specify: D12	ack
2	72 h	Completed	15. Decedent's E (Specify only highest gr	ducation a <i>de completed)</i>	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation du <i>ring</i> most of	f working	16b. K	ind of Business	/Industry
2	Atthin ne. hen	ш	Elementary/Secondary (0-12)	College (1-4or 5+))		17.		
7	tiled within 72 hours after death with the Maryland Hygiene. yther than "neturel", or liems 23a or 28e-f show yet, tha Medisal Examinar med be notified at	ပိ	12th 17. Father's Name (First, Middle, Lasi	Λ.	Clei	r K	40 14-11-1-	N (51 A61-1-		Gove	rnment
anc	be fi	Be		,				Name (First, Midd ie Cannon		Sumame)	
<u> </u>	d Mer nark natic	2	John Wynn	Time Orient	405 14-15					T	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examinat mat be notified at once.		19a. Informant's Name/Relationship		1	ng Address (Street a					Zip Code)
	1 and Healt em 2 ther		Romme 11 G. Holling 20a. Method of Disposition	ns, Sr./Friend	5214 Place of Dispo	Kilmer St	t. Chev	verly, MD		/85 ocation - City or	Town State
Baltimore,	ages or o		1 XBurial 2 ☐ Cremation 3	Removal from State	cemetery, crei	natory or other place	. 1		8		
ţ	rtmer rtent rtent		`4 □Donation 5 □Other (Speci			Memorial		20-06	_	tland,	
Bal	Deparent Dep		21. Signature of Funeral Service Lice	nsee		2. Name and Addres					
	EB 6 G		Phase	mare		217 9th.				, D.C.	
			23a. Part 1 Enter the disease, or com shock, or heart failure. List only	one cause on each line.	4			0	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Fital	and	eac A	Erhy.	thenex	/		Orisot and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	/	0				
L		_	Socialntially list conditions	b							
_	ed sit	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence or):						
	and I-trar	хап	that initiated events resulting in death) Last	c. Due to (or as a consec	nance of).						
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	icai E		220 (3 (2) 20 2 00.1000	400.100 0.7.						
œ	icate phys s the			_ d							
Box 6	death certifica attending pt d for use as t	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregn	ancv					20d Data of da	
Bo	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a	aldeath 3□	Ectopic pregnancy Other (specify)				23d. Date of de Month	Day Year
P.O.	he d / the ched	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	36411 56						
	that the de led by the a detached		Part II. Other significant conditions	contributing to death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Dio	I tobacco u	use contribute to	the cause of death?
ds	signed d be det	d by		-				1 [Yes 2	□No 3□Pi	obably 4 XUnknown
Division of Vital Records,	w requir been si should	Completed						04- 146		0.45 14/	4
že	has has	mp						24a. Wa	opsy formed?	prior to death?	utopsy findings available completion of cause of
<u>_</u>	Physicien: The this certificate har all director, page							1 ☐ Yes			2□ No
₹	certil recto	Be	25. Was case referred to medical examiner?	Hospital:		Othe	or	Death (Check only			
ot	Phys rthis ral di	. To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 🔀	ER/Outpatier 28b. Time o	II 3 DOA	4 U Nursir	ng Home 5 ☐ Re 28d. Describ			cify)
on	ding I h. After funer	tion	1 KNatural 5 ☐ Pending	(Month, Day Year)	Injury	Work	ເ?ົົ Yes 2 ∐ No	200. 2000112	3 11011 111101	, 00001100	
2	or Attending Physicien: after death. Director: After this certifica in by the funeral director, t	fica	3 Suicide 6 Could not b	18 280 Place of Injury - At h	ome, farm, str			28f. Location	(Street an	d Number or Ri	ural Route Number,
2	i Sir e	Certification;	4 Homicide determined	building, etc. (Speci	fy)	,			own, State		
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier 1 Certifying P	nysician: To the best of my kn	owledge, deat	n occurred at the tim	ie, date and p	lace, and due to th	e cause(s)	and manner as	stated.
	24 h	edical	(Check only 2 Medical Exa	miner: On the basis of examination and mapping stated.	ation and/or in	vestigation, in my op	pinion, death o	occurred at the time	, date and	f place, and due	to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	/		29c. License			29d. Dat	te signed (Mont	h. Day, Year)
	/			A COL		25	5895	7	/	- 15 -	06
	1-		30. Name and a ss of pers number	completed cause of death (Itel	m 23a) (Type,	Print)					
	り		70 (10/ 1)	ITTLE 30	D1 H	OSPITAL	DR	Cate	NERI	LY, MD	20185
	" Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature 6	And A		-//-			
	Regist	raŗ	JAN 1 9 200	completed cause of death (Itel ITLE 30 32. Registrar's Sign	1	3					

06-00187 B.K.S VANESSA B. WILSON

			For State Registrar	State of Marylar		artment of H rtificate of I			iene 006	01024
	Disconing		1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month		3. Time of Death
E	Physicia /Medic		VANESSA B. WILSO	N, JR.				JAN.	7. 2006	1544 P M
	Examin		4a. Facility Name (If not institution, give s PRINCE GEORGES HO	street and number) SPITAL CENTE	?	4b. City, Town, or CHEVERI		h	4c. County of Dea	th GEORGES
	Funeral Director		5// 23 82/4	M XXE	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JUNE 04	Year) C	thplace (State or Foreign ountry) SHINGTON, DC
	and ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Mary f sho	to	MD PRINCE G	EORGES TI	EMPLE H	TLLS				XXYes 2 □ No
	r 28s	Director	10e. Street and Number			10f. Zip Code		11	0g. Citizen of What Co	ountry?
	th wit	a D	2414 GAITHER STRE	ET		2	20748		UNITED S	STATES
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Item 27 is marked other then "neturel", or iteme 23s or 28s-f show other traumatic event, the Madical Examiner must be mailled at	d by Funeral	11. Marital Status XX Never Married 2	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes ※※ No	ispanic Origin? (S in, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi Specify: BL	te, etc.
15-(n 72 h *netu gulica	Completed	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occup kind of work done of DO NOT use retired	during most of wo	rking	16b. Kind of Business	/Industry
12	within iene. then	шо	Elementary/Secondary (0-12) 8TH	College (1-4or 5+)		DENT	,			
d	illed Hygi other	BeC	17. Father's Name (First, Middle, Last)) 510	DENI	18. Mother's Na	me (First, Middle, M	Maiden Sumame)	
/lar	should be ind Mental marked o	ToB	CLIFFORD KITT				VANESSA	WILSON		
Maryland	2 sho and I		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Street	and Number or Ru	ıral Route Number	City or Town, State,	Zip Code)
	l and leelth im 27 her tr			CIAL WORKER		SIXTH ST.	SW WAS		DC 20024	
Baltimore,			20a. Method of Disposition XXBurial 2 □ Cremation 3 □ R	emoval from State	cemetery, crei	sition (Name of matory or other place	1		20c. Location - City or	Town, State
뜵	it. Pa rtmer rtent njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			ION CEMET			CLINTON,	
Ba	permit. Page Depertment of Important: if any injury or		P. Mary	ll		MARSHALL 4308 SUI			OF MARYLAN LAND, MD 2	
			23a. Part 1 Enter the disease, or compli shock or heart failure. List only or	cations that caused the dea ne cause on each line.	ith. Do not en	er the mode of dyin	g, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	HEA	27	DISEASE				Oliset and Death
	Examiner			Due to (or as a conse	quence of):					
	^	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quanca of):					
	uted d anslt	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
o,	exec en an rial-tr	Exa	resulting in death) Last	Due to (or as a conse	quence of);					
68760,	ficate be executed physicien and is the burial-transit	edical		t						
		Med	IF FEMALE:						1000	
P.O. Box	law requires thet the death certif as been signed by the ettending c 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of preging the birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	s thei	by P	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tot	pacco use contribute t	o the cause of death?
ğ	w requires to been signer should be	ted	ASTIMA	-		_		1 □ Ye	s 2) X (√0 3□P	robably 4 Unknown
of Vital Records,	The ate h page	Completed						24a. Was a autops perform	y prior to death?	utopsy findings available completion of cause of s 2 No
Vita	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	lospital:		Oth	00	ath (Check only on	-/	
o		2	1 XYes 2 No	1 Inpatient 2)	ER/Outpatie		4 Nursing r		ence 6 Other (Spectow injury occurred	ecify)
	ding Ih. Th. After funer	tion	1 Natural 5 Pending investigation	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No	200. Describe no	ow injury occurred	
Division	al or Attendir efter death. f Director: Af d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec				28f. Location (St City or Town	reet and Number or R n, State)	lural Route Number,
Δ	urs of urs of aref D									
	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Attencompletely filled in by the fune	Medicai	29a. Certifier (Check only one) 1 ☐ Certifying Physical Examination (Check only one)	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, deat nation and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occ	e, and due to the ca urred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. Licens		2	9d. Date signed (Mon	
•	4			1		0.	C.M.E		JAN. 8, 2	2006
	/		30. Name and a gress of per on the great Case	7 1/1 1			, BALTIM	ORE, MARYI	AND 21201	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature					
	Regist	ar	JAN 1 9 20	106	D. As	Marie B				

	1	For State Registrar	State of M	arylan				ealth a Death	and Mer		giene Reg. No.	200	5 010
Physician /Medical	1	I. Decedent's Name (First, Middle, La Kathy Kelari	1. 14/:1	n						Date of Dea Month	Day	Yea 200	7 7 1 1 4
Examiner		a. Facility Name (If not institution, given North West Hospi S. Social Security Number 6.5	tal		ast birthday)	Bar		town	of Death	Date of Birt	4c. (altim o	10
Funeral Director		,	I□M 2风F	50	Yrs.	Months	Days	Hours	Jun	(Month Day ie 30,	195!	5	irthplace (State or Fo Country) Maryland
show		Oa. State 10b. County Maryland Carrol		1	, Town or Lo dersbu								10d. Inside City L
or 28a-f si te notified Director	3	Oe. Street and Number	-	LL	derso		ip Code				10g. Citiz	en of What (
at of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic event, the Medical Examinations than rutilisal at or other traumatic event, the Medical Examinations and Director To Be Completed by Funeral Director		1699 King Richan 1. Marital Status 1. Never Married Married 3. Widowed 4. Divorced	12. Was Decedent Armed Forces? 1 Yes, Give Year or Dates:)		Was Dec If Yes, sp	ecrly Cuba	spanic Orio	gin? (Specify , Puerto Ric	Yes or No-	. 1	State 4. Race - An Black, Wh	•
ygiene. ner than "natural it, the Medical E.	neight	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed) College (1-4or	5+)		dent's Us kind of w DO NOT ne Ma	ork done d use retired	ation during most	t of working			d of Busines	
nd Mental Hygis marked other amatic event, II	ם	12 17. Father's Name (First, Middle, Lasi George John Kola							er's Name <i>(F</i>				
and N		19a. Informant's Name/Relationship	Type, Print)			-	•	and Numbe	er or Rural R	oute Numbe		,	
Department of Health Important: If Item 27 I any injury or other tru	-	Mark Will 20a. Method of Disposition 1 □ Burial 2 ☐ Cremation 3 ☐ 4 □ Donation 5 □ Other (Speci	Removal from State	20b. P	1699 lace of Dispo emetery, crea tro Cr	osition (Na matory or	ime of other plac	a)	Road, Date 01/19/	106	20c. Loc	ation - City of	yland 2178 or Town, State Maryland 2
ysician	-	21. Signatury of Funeral Service Lice 23a. Part I. Enter the disease, or senshook, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	polications that cause	ine.	n. Do not en	728	Liber		pad, R	anda11	stow	unera m, Ma	L Director ryland 211 Approximate Interval Betwee Onset and Deal
physicien and supposed in the purial transit supposed in the purial transit supposed in the purial transit supposed in the purial transition in th	dical Examine	Securitian flet on ultions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Cardio Due to (or as Due to (or as Multi	pulm consequ	enary uence of):		rest						
igned by the ettending I be detached for use es by detached for use es by Physician/Me	yarciaitima	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3]Ectopic] Other (s	pregnancy				2	3d. Date of d Month	lelivery Day Year
been signed by should be deta	led by Fi	Part II. Other significant conditions	contributing to death t	out not resu	uiting in the u	inderlying	cause give	en in Part I.			bacco us		to the cause of deati
is certificate has been si director, page 2 should To Be Completed											sy med? 2 No	death'	autopsy findings avai o completion of cause es 2 \sumbed No
his certi	0	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No	Hospital:	ent 2K	ER/Outpatier	nt 3□ E	OA Othe	20	of Death (Corsing Home			□Other (St	Decify)
rs effer death. rs al Director: Affer this ed in by the funeral di	allon;	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		iry iy Year)	28b. Time o Injury		28c. Injun		28d	. Describe h			
		3 Suicide 6 Could not I determined	building, e	tc. (Specify	v)					City or Tow	m, State)		Rural Route Number,
n 24 hou he Fune pletely fil	מוכק	(Check only 2 Medical Exa	hysician: To the best miner: On the basis of and manner st	of examinat	tion and/or in	vestigatio	n, in my og	pinion, deat	th occurred a	at the time, o	date and	place, and di	ue to the cause(s)
To the compl		29b. Signature and title of certifier				2	c. License	number			29d. Date	signed (Mo	nth, Day, Year)
		Marita nec	kend Bro	me?	m.D.		DO	050	332		Janu	ary 13	5,2006
State Registrar	9	29b. Signature and title of certifier Muta Nuc 30. Name and address of person who MANIA NICKEAS 31. Date filed (Month, Day Year)	BROOME 32. Regin	death (Item 540/ rar's Signa	23a) (Type, OLC C	Print)	Rot	D, TRA	rudtle	Stow	N, NI	Angli	rd 2113

			State of Maryland / Department of Health and Mental Hygiene 0 6 0 1 2 6 Certificate of Death Reg. No.
	D: ::		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year
	Physicia /Medic		HENES WISEMAN JANUARY 11 2006 12:50 PM
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
			MARIEU NECK HEALTH AND KENAB. GLEN BURNIE ANNE ARUNCES. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Touris Touris
	p		Usual Residence of Decedent
	shov	or.	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Iaryland Anne Arundel Glen Burnie
	28a-f	ect	lary I and Anne Arundel Glen Burnie 106. Street and Number 107. Zip Code 109. Citizen of What Country?
	within 72 hours after death with the Maryland ene. Ithan "natural", or Itams 23a or 28a-f show Ite Meulcal Eranirer mant be notified at	Funeral Director	7575 E. Howard Road 21060 U.S.
	death mms 2 r mm	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
စ္တ	or Its	y Fu	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specific White
21215-0036	hours tural',	ed by	3 M Wildowed 4 Divorced Year or Dates:
15	in 72 n "nai	piete	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired!
212	d with	mo	6th College (1-4or5+) Waitress Restaurant
ng	al Hy d othe	Be Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
yla	should be f and Mental H s markad of umatic eva	70	Earl Edward Handschumacher Mary Margaret Stewart
Maryland	12 sh h and 7 Is rr traurr		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Rural Route Number, City or Town, State, Zip Code</i>) Kathleen Gorman / niece 744 Villager Circle Baltimore. Maryland 21222
e,	1 and Heali tam 2		20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. location - City or Town State
Θ E	Pages ent of nt: If i		1 Burial 2XICremation 3 Removal from State Bayview Crematory 1/18/2006 Baltimore, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healin and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A.
<u> </u>	88 8 8		January Engineering 4001 Ritchie Highway Baltimore, Maryland 21225
			23a/Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
F	Physician		Immediate Cause (Final disease or condition resulting in death) a. Onset and Death Onset and Death
	/Medical Examiner		Due to (or as a consequence of):
		jer	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury b. Due to (or as a consequence of): Cause (Disease or injury
	cuted nd ransit	Examiner	that initiated events C.
ő,	cate be executed obysician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence of):
8760,	The law requires that the death certificate be executed tie has been signad by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	d
9 X	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery
Вох	death a atter d for u	iciar	in the past 12 months? 1 Uve birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month Day Year
P. O.	that the death cer ad by the attendir detached for use	hys	9 Unknown 9U Unknown
s,	w requires that s been signad t should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
of Vital Records,	requi	Completed	Dear O 1 Ch 2 to 1
3ec	ne faw has b ge 2 s	mpi	24a. Was an autopsy findings available prior to completion of cause of death?
a	ician: Th certificate rector, pag		1
Ē	Physician: r this certifica ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 26. Place of Death (Check only one) 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify)
10	ding Phys h. After this funeral di	T :uc	27. Manner of Death J Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Work?
sioi	Attanding ar death. actor: Afte by the fune	catic	Accident investigation M 1 Yes 2 No
Division	I or Attank after deatl Diractor: I in by the	Certification;	Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town. State)
	spital iours a neral filled		29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the To the Comp	ž	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	Α		D57028 1.13-06
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature
	Registr		31. Date filed (Month, Day Year) 2006 32 Registrar's Signature

DHMH 17 Rev 1/2001

9 2006

			1 - State Registrar	State of Marylan			nt of H			jiene _{leg. No.}	06	01028
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Dorothy	Perry Allen					2. Date of Dea Month Janua:		,2008	3. Time of Death 8:05PM M
À.	Examin		4a. Facility Name (If not institution, give s. Casey House	treet and number)		4b. Cit	y, Town, or OCKVi	Location of Dea	ith		inty of Death tgomery	у
ŧ	Funeral Director		3,, 3. 3333	M X F 7. Age (In yrs.	last birthday) Yrs.	If Und Month	er 1 Year s Days	If Under 24 Hr. Hours Min		Year) , 191	Coun	lace (State or Foreign stry) ginia
•	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hyglene. Department of Heelih and Mental Hyglene. Instructural; if item 27 is marked other than "natural; or items 23s or 28s-f show amyloriquit if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avent, ite Medical Examinat must be notified at once.	Funeral Director	Usual Residence of Decedent 10a. State 10b. County Virginia Fairfax 10e. Street and Number 1437 Mayflowe 11. Marital Status 1 Never Married 2 Married	r Drive 2. Was Decedent Ever in U Armed Forces?	II	10f. 2 Vas Dec	ecify Cubar	spanic Origin? (, Mexican, Pue	Specify Yes or No-	Uni 14.1	of What Counted Sta	ates an Indian,
3 21215-0036	filed within 72 hours a Hygiene. ther then "natural", o nt, the Medical Exer	Completed by	3 M Widowed 4 □ Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) UNKNOWN 17. Father's Name (First, Middle, Last)	1 Yes, GYM No If Yes, Give 1 Year or Dates: sation completed) College (1-4or 5+)	16a. Deced	lent's Us kind of v	vork done di use retired)	uring most of wo	orking ame (First, Middle,	16b. Kind o	f Business/Inc	White
aryian	should be and Mental marked o	To Be	Joel P. Harris 19a. Informant's Name/Relationship (Type		19b. Mailin	g Addre	ss (Street a	Gertr	ude Steel	e . City or To	wn. State. Zip	Code)
Баппоге, маг	ermit. Pages 1 and 2 epartment of Heelth a nportant: if ttam 27 ii ny injury or other tra nce.		Mildred Thompson 20a. Method of Disposition 1\(\) Burial 2 \(\) Cremation 3 \(\) Re 4 \(\) Donation 5 \(\) Other (Specify) 21. Signature of Funeral Service License	emoval from State 20b. p. Be1	lace of Disposemetery, crem	sition (N natory of ted	ame of other place Metho	Jan 2 dist Ce	metery	20c. Location	on-City or To	wn, State
8/60,	Physician product street product street product street str	dical Examiner	23a. Part. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	re Hear uence of):				ac or respiratory arr	est,		Approximate Interval Between Onset and Death
O. Box 68	death certi	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12, months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of di 9 ☐ Unknown	death 3	Ectopic Other (pregnancy specify)			23d.	Date of delive Month	ry Day Year
ecoras, r	law requires that the as been signed by th 2 should be detache	Completed by Pi	Part II. Other significant conditions cont	inbuting to death but not resi	ulting in the un	iderlying	cause give	n in Part I.	1 □ Ye 24a. Was a	n 24	3 Proba	ably 4 Unknown osy findings available npletion of cause of
VITAIL IN	in: The ificete hi or, page	e Com	25. Was case referred to medical					00 Disease (De		ned? 2∭ No	death?	
IO TO HOIS	To the Hospital or Attending Physicien: The law within 24 bours effected death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3 🗆 C	Other	4 Nursing	eath (Check only on Home 5 Reside 28d. Describe ho	ence 6 □		v)
DIVISION	pital or Attu urs efter de arel Directo	Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	<i>'</i>)				28f. Location (Si City or Town	n, State)		
	To the Host within 24 ho To the Fund completely f	Medical	29a. Certifier (Check only one) 2 Medical Examinone) 29b. Signature and title of certifier 30. Name and address of person who con	ician: To the best of my kno er: On the basis of examina and manner stated.	lion and/or inv	estigatio	d at the time n, in my opi	nion, death occ	urred at the time, d	ate and place 9d. Date sig	manner as state, and due to gned (Month, L. y. 17, 2	the cause(s) Day, Year)
	Sta Registr		Charles Harrison M		aster N		Road	Rockvil	lle, Mary	land 2	20852	

			1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 1	029
	Physici /Medi		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Clizabeth Ambrose 2. Date of Death Month Day Year Clizabeth Ambrose	e of Death
	Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
₩;	Funeral Director		Franklin Square Hospital Rossville Baltimore 5. Social Security Number 6. Sex 1 Months Days Hours Min. 10/28/1922 Pennsylva 83 Yrs. Baltimore Ba	
N	D ≥		Usual Residence of Decedent	e City Limits
124	after death with the Maryland or teme 23a or 28e-f ehow	Director	Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	∕es 2X No
7	th with 23a or	ai Di	352 Poplar Road 21221 U. S. A.	
336	or Ite	by Funeral	11. Marital Status 1	1,
215-06	72 hc	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	
9 2	filed w Hygier other th	e Cor	12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
Z Name	should be filed within and Mental Hygiene. I marked other then umatic event, the Ma	To Be	Richard J. Ryan Erma Clementine Ceuleer	
Man	12 sho h and l 7 is ma	i	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter)	7
Q e	s 1 and if Health Item 27 other to		Elizabeth Rita Stewart 300 Riverside Road Essex, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	9
Z	Pages ment of ant: If It ury or o		4 Donation 5 Other (Specify) Bayview Crematory 2006 Baltimore, Mary.	land
Balti	permit. Pages Department of Importent: If I eny injury or one		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA	21221
	Physician		23a. Part 1. Enter the disease. If complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately a condition and a condition are sufficiently and a cardiac or respiratory arrest. Approximately a condition and a condition are sufficiently arrest. Approximately a condition and a cardiac or respiratory arrest.	
8760.	Cate be executed cate be executed bhysiclen and the burial-transit	dicai Examiner	resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
P.O. Box 68	the Hospital or Attending Physician: The law requires that the death certificating 24 hours after death. The Funeral Director: After this certificate has been signed by the attending phypletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Year
	v requires that the de been signed by the a should be detached f	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the ca	
ok per brante.	: The law requir cete has been si , page 2 should	Completed	24a. Was an autopsy finding autopsy performed? 1 Yes 24 No 1 Yes 2 No	ngs available of cause of
<u> </u>	reician: Th s certificete director, pag	To Be	25. Was case referred to medical examiner? 1 New State 26. Place of Death Check only one 1 No State 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	
ok r	onding Physician: ath. ir: After this certific te funeral director.		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year) 2 Recident 28b. Time of Injury Work? M 1 Yes 2 No	
Divig	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route City or Town, State)	Vumber,
	Hospi 24 hou Funer etely fil	edicai	29a. Certiflier (Check only one) Certifling Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cau and manner stated.	se(s)
~	To the within To the comple	Me	29b. Signature and title of certifier 29d. Date_signed (Month, Dey, Yea	er)
	6	ate	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tho Mas Krisanda 9000 Franklin Square Drive Balt Mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature	2123
	Regist		JAN 2 0 2096 Brown & Sports	•

			1 - For State Registrar	State of Mar		artmen rtificate					13 /3 /	16	01030
	Physici		Decedent's Name (First, Middle, Last DONAL D)		ANS	SHEL			Date of Death	15 ^{ay} 2006	Year	3. Time of Death 4:25 P M
	/Medio Examir		4a. Facility Name (If not institution, give	OF CORRECTI		4b. City,	Town, or	Location o			4c. County	of Death	
	Funeral Director		210 34 3000	X 7. Age (i	n yrs. last birthday) 72 Yrs.	If Under Months	1 Year Days	If Under Hours		Date of Birth (M23/19	33	9. Birth	place (State or Foreign intry) MD
	Maryland I-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County MD ANNE ARUI		Oc. City, Town or Lo	ocation							10d. Inside City Limits 1 ☐ Yes 2 No
	with the	i Director	10e. Street and Number MCI-J P.O. BOX	549		10f. Zip				10	g. Citizen of V		intry?
036	72 hours after death with the Maryland "natural", or Itama 23a or 28a-f ehow solical Examinational be notified at	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Amed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates:	er in U.S. 13.	Was Deced	lent of Hi	spanic Ori n, Mexican Specify:	gin? (Specify i, Puerto Rica	Yes or No- an, etc.)		e - Ameri k, White	ican Indian,
Maryland 21215-0036	d within giene. ir then "	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) Colfege (1-4or 5+) 5+	(Give	dent's Usua kind of wor DO NOT us OUNTAN	rk done d se retired	during most	t of working	1	6b. Kind of Bu		·
/land	d o d	To Be	17. Father's Name (First, Middle, Last) BERNARD	5	AN:	SHEL			er's Name <i>(Fi</i> ROTHY	rst, Middle, M	la <i>iden Sur</i> nam	_{e)} PHEL	PS
e, Mary	1 and 2 sh Health and em 27 is m ther traum		19a. Informant's Name/Relationship (T) LOUIS JACOBS / F 20a. Method of Disposition		5750 20b. Place of Dispe	PARK psition (Nam	HEI ne of	GHTS		[‡] 286 -	City or Town, BALTIM Oc. Location -	ORE,	MD 21215
Baltimore,	permit. Pages Department of I Important: If It eny injury or o		1 X Burial 2 Cremation 3 1 4 Donation 5 Other (Specify, 21. Signature) 1 Funeval Service License	20	BALTIMOR	E HEB	REW	CEMO		2006		MORE	, MD
8	88188		23a. Part1. Enter the disease, or comp shock, or heart failure. List only d	Jugar Jications that caused th	8	900 RI	EIST	ERST0	WN ROA	D - PI	KESVIL		MD 21208 Approximate
>	Physician /Medical Examiner		snock, or near tailure. List only be Immediate Cause (Finat disease or condition resulting in death)	Card	JOMYOR	athy							Interval Between Onset and Death
79		Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. CAD Due to (or as a c	consequence of): S P consequence of):	MI		1	LUD	ردع			
8760,	cate be executed obly sician and the burial-transit	dicai	resulting in death) Last	Due to (or as a d	onsequence of):	Live	e V	(e	si on	£.			
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 (4 Pregnant at tin 9 Unknown	Fetal death 3	□Ectopic pro □ Other (spe					23d. Date Mor		rery Day Year
Q	w requires that been signed b should be deta	þ	Part II. Other significant conditions co	ntributing to death but r	not resulting in the u	inderlying ca	ause give	en in Part I.				ibute to	the cause of death?
Il Records,		Completed								24a. Was an autopsy perform 1 Yes 2	ed?	rior to co leath?	opsy findings available ompfetion of cause of 2. No
f Vital	Physicien: T this certificat al director, pa	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 🗆 DO	A Othe) F		heck only one 5 🗌 Resider		/NS7	TITUTION
Division of	ath. r: After	Certification:	27. Manaer of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Y		м		rat ⟨? Yes 2□	No		w infury occurre		
Div	2 4 5		4 Homicide determined	28e. Pface of Injury building, etc.	(Specify)					City or Town,	State)		al Route Number,
	To the Hospital within 24 hours a To the Funerel Completely filled	ledical	one) Medical Exam	rsician: To the best of a liner: On the basis of example manner state	kamination and/or in	ivestigation,	, in my op	oinion, dea	d place, and th occurred a	due to the cau	use(s) and ma te and place, a	nner as s and due t	stated. to the cause(s)
	To vitl	×	29b. Signature and title of certifier	resper	7 '	290	Cucense	O S	333) 29	Janua Janua	(Month,	8 2006
)			30. Name and address of person who e	empleted cause of deal MESGEN	th (ttem 23a) (Type	Print) 7	55	wa.	Her L	00 12	d atg	Rt	175
1	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature							1	

			For State Registrar	State of		d / Depa		of He	ealth a		ental Hygi		06	01031
	hysicia /Medic		1. Decedent's Name (First, Middle, La: Mildred Ann Burro								2. Date of Death Month January	Day	200g	3. Time of Death 7:40 a M
	Examin		4a. Facility Name (If not institution, given Stella Maris	street and numb	er)		4b. City, T		Location o	f Death		1	ty of Death	<u>-</u>
	uneral rector		5. Social Security Number 6. S 217-22-4027	ex 7. □M 2□F	Age (In yrs. 1	last birthday) Yrs.	If Under 1 Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, May 22,	1927	9. Birthi Cour Mary	place (State or Foreign ntry) Land
Maryland	Is a show	tor	Usual Residence of Decedent 10a. State 10b. County Md. Harfor	d	10c. City	, Town or Lo	cation Abin	gdon					1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the	3a or 28a	Direc	10e. Street and Number 602 Forfar Court				10f. Zip (Code	009		10	ng. Citizen o	f What Coul	ntry?
Baltimore, Maryland 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	al', or Items 2: Examiner mus	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	as? ⊠No		Was Decede f Yes, speci 1 Yes 2	ent of His fy Cubar	spanic Orig n, Mexican	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	14. R	ace - Americ lack, White, hify: Whi	etc.
Z I Z I 3-UUSO sd within 72 hours afl giene.	than "natural is	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12 years	ducation de completed) College (1-4	or 5+)	16a Deced (Give life. I	kind of work DO NOT use	k done di	urina most	of worki	ng	legal County	(Anne	Arunde1
Maryland 2 nd 2 should be filed lth and Mental Hygi	rrked other	To Be C	17. Father's Name (First, Middle, Last, Elmer Soper								(First, Middle, A	faiden Sum	ame)	
, Mary and 2 sho alth and 1	27 is ma er traume		19a. Informant's Name/Relationship (Raymond Burrows		lson						I Route Number, ingdon,			Code)
Baltimore, permit. Pages 1 at Department of Hea	ant: If Item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other (Specif	Removal from Stay) mausole	20 0	lace of Dispo emetery, cren 11y Hi	natory or oth	her place				20c. Location Middl		own, State
Departr	Importa sny Inje pnce.		21. Signature of Funeral Service Licer	nsee	بىر						Home of ad, Bel			
/Me Example of executed	been signed by the attending physician and should be detached for use as the burial-transit and a larger transit.	licai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. Sequentially list conditions. Large large cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or c.	h line.	wence of):		y or dying	, such as	cardiac	respiratory arre	st,		Approximate Interval Between Onset and Death
VISION OF VITAL MECORDS, P.O. BOX OR Attending Physician: The law requires that the death certifica react.	y the attending p sched for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ⊡ Feta ntattime of d	Ideath 3□	Ectopic pre Other (spe						Date of deliver	ery Day Year
quires that	en signed b		Part II. Other significant conditions of	contributing to dea	th but not res	ulting in the u	nderlying ca	use give	n in Part I.			acco use co s 2 □ No		he cause of death? pably 4 Junknown
VITAL MECOFA sician: The law requir	ificate has be or, pa⊜e 2 sh	e Completed	25. Was case referred to medical	Į.					26 Place	of Dogeth	24a. Was ar autops perform 1 Yes 2	ned? No	D. Were auto prior to co death? 1 \(\sum \text{Yes} \)	opsy findings available impletion of cause of 2 No
DIVISION OF VI Lor Attending Physici after death.	To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of (Month,		ER/Outpatien 28b. Time of Injury		Bc. Injury Work	r: 4 Nu	rsing Hor	ne 5 Reside 28d. Describe ho	nce 6 🗆 C		(y)
UIVIS tal or Atters rs after dea	al Directo ed in by th	Certification:	3 Suicide 6 Could not be determined	286. Place of	f Injury - At ho , etc. <i>(Specif</i>	ome, farm, str	eet, factory,	, office			28f. Location (Sti City or Town	reet and Nut , State)	nber or Rura	al Route Number,
To the Hospital or within 24 hours afte	the Funer ppletely fill	ledicai	one) 2 Medical Exe	nysicien: To the b miner: On the bas and manne	is of examina	wledge, death tion and/or in	vestigation,	in my op	inion, dea	d place, a	ed at the time, da	ite and place	a, and due to	o the cause(s)
To	or co	Σ	29b. Signature and title of certifier					License		25		d. Date sign		
	6		30. Name and address of person who	HMOD.	D.M.	D.	Print)	23 Ti	200	D	man	ey	Valle 210	6 24 Road 93
	Sta Registi	-	JAN 2 0 20		gistrat's Signa	iture	and I				, ,			

JANUARY 16, 2006 @ 7:40 AM

BURROWS, MILDRED

		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 0 6 0 1 0 3 2									
÷.	Physicia /Medic		1. Decedent's Name (First, Middle, Las	ANN	Burg	ess	2. Date of Death Month January	Day 13, 2006	3. Time of Death 5: 25pm M		
	Examin	er	4a. Facility Name (If not institution, give Greater Baltimore	Medical Cente	r To	y, Town, or Location of Death DWSON ler 1 Year If Under 24 Hrs.		4c. County of Death Baltimor	e		
* *	Funeral Director		5. Social Security Number 6. Social Security Number 10 11 Usual Residence of Decedent	7. Age (In yrs.	Yrs. Month		8. Date of Birth (Month, Dev.)	1945 ma	hplace (State or Foreign unity) Yyland		
:	death with the Maryland ms 23a or 28a-1 ahow richal be notified at	ctor	blauare 500	Sex 10c. Cit		ro			10d. Inside City Limits 1 ☐ Yes 2 V No		
	eath with tr	Funeral Directo	10e. Street and Number 24347 Ken+	DY I VC 12. Was Decedent Ever in U		Zip Code 19966 redent of Hispanic Origin? (Sp.		. Citizen of What Co			
	n 72 hours after death with the Marylan "natural", or Itams 23a or 28a-1 show colcal Expolicer found be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White			
0 7	nd 2 should be filed within lith and Mental Hygiene. 27 Ia marked other than r traumatic avent, train	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of v life. DO NOT	vork done during most of work	ing 16	b. Kind of Business/I	industry		
/land 2		To Be Co	17. Father's Name (First, Middle, Last)	Kins	1 101	18. Mother's Name	e (First, Middle, Ma	iden Sumame) Bond	0///		
e, Mary			Wibur M. B	Type, Print)	19b. Mailing Addre	ss (Street and Number or Run	Sboro, C	KL. 199	166		
Baltimor	permit. Pages 1 al Depertment of Hee Important: If Itam any injury or otha once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specification 21. Signal Proof of Fundral Service Licen	Removal from State	dens of fai	th 1/2	1/06 /3	c. Location - City or Cocchile	maryland -BeltiR		
F	hysician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	lic tions that caused the deat no cause on each line.		1 1	2 1	entesis	Approximate Interval Between Onset and Death		
/ / no	be executed cien end cien end purial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. hemati Due to (or as a consequence of the conseq	- of la	rge histal	herni	ص	1days		
	death certific e attending p	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregns 1 Live birth 2 Feta 4 Pregnant at time of c	I death 3 Ectopic			23d. Date of deli Month	very Day Year		
rds, r	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
ř	the last	Completed			. Was an autopsy performed? Tes 2 \(\text{No} \) No \(\text{1} \) Were autopsy findings available prior to completion of cause of death? \(\text{1} \) Yes \(2 \) Hvo						
5	sician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner? 1 Yes 240	Hospital:	ER/Outpatient 3 []	Other	h (Check only one)	2 Flore 10			
ō	g Phy er this eral d	 	27. Manper of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28d. Describe how		ciry)		
Sion	andin sath. or: Aft he fun	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	1	M	1 Yes 2 No					
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director;	Certification;	3 Suicide 6 Could not be determined	building, etc. (Special	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	A Hosp 24 ho A Fune letely fi	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and place, on, in my opinion, death occurr	and due to the caus red at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)		
ı	To th withir To th comp	Me	29b. Signature and title of certifier	o MO	2	9c. License number		Date signed (Month			
	12		30. Name and address of person who		n 23a) (Type, Print)	s St. Tows					
34	Sta	ite	31. Date filed (Month, Day, Year)	32, Registrar's Signa	11- Maile	5 05, 1000	son ius	21204.			

Burgess, Janice

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	4	For State	State of Marylar	•	nt of Health and late of Death		2006 01033
		Registrar 1. Decedent's Name (First, Middle, Las		TO III:	ne or Death	2. Date of Death	3. Time of Death
Physici: /Medic	al -	William	Kussell	Battle		1 1	\$ 2006 10:37M
Examin	er	4a. Facility Name (If not institution, give	nule He.	tue 16. Cit	y, Town, or Location of Deat	ا ر 🗗	c. County of Death
Funeral Director		5. Social Security Number 6. Security 144 6. Security Number 6. Security Number 144 7830 10 Usual Residence of Decedent	55-1011	A Yrs. If Unc			9. Birthplace (State or Foreign Country) Maryland
ryland how		10a. State 10b. County	10c. C	ity, Town or Location			10d. Inside City Limits
with the Maryland a or 28a-f show	ecto	10e. Street and Number	B	altimo	In Code	100 (1
U36 ours after death with the Marylan raf; or items 23e or 28e f show Examples matter matter at	Funeral Director	2019 E. Late	avette A	rue "	21213		USA
ter death Items 23	-uner	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in the Armed Forces?	J.S. 13. Was Dec If Yes, sp	pedent of Hispanic Origin? (Specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
5-0030 72 hours after natural; or ite	by	3 Widowed 4 Divorced	tf Yes 2 □ No tf Yes Give Year or Dates:		25 No Specify:		Specify: Black
	Completed	15. Decedent's Ed (Specify only highest gran	de completed)	16a. Decedent's Us (Give kind of life—DO NOT	vork done during most of wo	rking 16b.	Kind of Business/Industry
d Z1Z1 filed within Hygiene. sther than " ant, the Mas		Elementary/Secondary (0-12)	College (1-4or 5+)	Dr	ver		ransportation
ryland should be fil od Mental H marked ott matic even	To Be	17. Father's Name (First, Middle, Last)	. 1110		8. Mothers Na	me (First, Middle, Maid	en Sumame)
6 8 8 8	-	19a. Informant's Name/Relationship (7	ype, Print) (Sou)	19b. Mailing Addre	ss (Street and Number or Ri	ural Route Number, City	v or Town, State, Zip Code)
re, M 1 and 2 Health tem 27	(ameron 5 1	Sattle 20b.	Place of Disposition (A cemetery, crematory of	lame of	Date 20c.	Location - City or Town, State
O 8°= 5		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify	nemovas nom State		Stemeter 1	25/00 a	Ungs Mills MD
Baltim permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Licen	Series Sin	Va Name	and Address of Fa	en esta	seral Services
25.34		23a. Part1. Enter the disease, or compshock, or heart failure. List only	plications that caused the dea	ath. Do not enter the m	ode of dyin such as cardia	c or respiratory arrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	. Hype	rtensiv	e Vascu	lar Dis	ease Syears
/Medical Examiner			Due to (ar a) conse	quence of):	rellitus	tupe IL	Surare
T pg is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):	Mana		
8760, sate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	11/200				
the state of	dicai	•	d. 1000	acco 1	15e 13750	order	gears
. BOX 68 death certific e attending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr				23d. Date of delivery
. 0 0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown				Month Day Y⊕ar
hat the d by detac	by Physician/Me	Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlying	g cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
Vital Records, sloien: The law requires to certificate has been signe rector, page 2 should be contracted.						1 ☐ Yes	2 No 3 Probably 4 Unknown
Reco	Completed				· · · · · · · · · · · · · · · · · · ·	24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
ian: Ti	Be Co	25. Was case referred to medical			26. Place of De	1 ☐ Yes 2 Attack only one)	No 1 Yes 2 No
Of V Physic this ce al direc	ို	examiner?		ER/Outpatient 3		1	6 □Other (Specify)
ION ording Fath.	ation:	27. Manner of Ceal Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how in	gury occurred
DIVISION OF I or Attending Phy after death. Director: After this fin by the funeral d	Certification:	3 Suicide 6 Could not be 4 Homicide determined	et and Number or Rural Route Number, State)				
Division of Vital Refused to the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical Co	29a. Certifier (Check only one) Certifying Ph	ystcian. To the best of my kr niner: On the basis of examing and manner stated.	nowledge, death occurrination and/or investigati	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
within To the comple	Me	29b. Signature and title of contifier		4	29c. License number	29d. (Date signed (Month, Day, Year)
		PRANTAX (arms		D5344	45	1/20/2006
10		30. Name and Iddress of person who	completed cause of death (Ite	om 23a) (Type, Print)	The Alan	neda Bu	Utimore MD 21218
Sta		31. Date filed (Month, Day, Year)	32 99 istrar's Sign	nature			70

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar		State of	f Maryland		artment			and M	-	giene Reg. No:	06	01034	
	Physicia	an	1. Decedent's Name (First		Bark	_						2. Date of De Month January	Day)6 ^{Year}	3. Time of Death 11:50 PM	
2	/Medic		Alma 4a. Facility Name (If not in	L.				4b. City.	Town, or	Location o		ouract y		y of Death		
	Examin	er	7248 Meadow	_		,			unda]					Baltimore		
16.	Funeral		5. Social Security Number	6. S		7. Age (In yrs. I	ast birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birt	th V Voarl	9. Birth	place (State or Foreign	
**************************************	Director		220-26-7558	1	□M 2X7F	74	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Pa April	1,1931	Mar	yland	
	pur		Usual Residence of Dece 10a. State 10b.	County		10c City	r, Town or Lo	cation							10d. Inside City Limits	
	eho eho	5		N/A			ltimo								1 X Yes 2 □ No	
	28e-1	Director	MD 10e. Street and Number	IV/ FA			LI CIMO.	10f. Zip	Code				10g. Citizen of	What Cou	ntry?	
	with Sa or	급	1018 Evans W	Jav				тот. Др	2120)5			USA	What ood		
	death ma 23	Funeral I	11. Marital Status	, ay		dent Ever in U.	S. 13.	Was Deced			gin? (Spe	cify Yes or No Rican, etc.)	- 14. Ra		can Indian,	
9	or ite	Ē	1 Never Married 2	! Married	Armed Fo	2 No		-			i, Puerto I	Rican, etc.)		ack, White	, etc.	
8	ral', c	b	3 □ Widowed 4 🛣	ivorced	If Yes, Giv Year or D	ates:		1 ☐ Yes 2	ZINO	Specify:			Speci	^{ry:} Wh	ite	
21215-0036	itied within 72 hours after death with the Maryland Hygiene. ther than 'natural', or items 23s or 28e-f show ort, the Madical Examiner must be notified a	Completed		ecedent's Ed by highest gra	ducation ide completed)		(Give	dent's Usua kind of wor	rk done d	uring most	t of workii	ng	16b. Kind of B	Business/Ir	ndustry	
7	within	m	Elementary/Secondary	(0-12)	College (1	-4or 5+)		DO NOT us			_		Polv	Coal		
N D	Hygie ther t		8 years 17. Father's Name (First,	Middle, Last)		Ма	chine	Ope			(First, Middle,	Maiden Suma			
ano	d be antal	o Be										e Gero				
Maryland	permit. Pages 1 and 2 should be itied within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or itema 23a or 28e-f ehow ampringing or other treumatic event, the Madical Examiner must be notified at ance.	ဥ	James M. Hos		Type, Print)		19b. Maili	ng Address	(Street a				er, City or Town	n, State, Zi	p Code)	
Š	nd 2 ilth ar 27 is r freu		Linda Kehoe		Dau	ghter		-					21222			
re,	s 1 al f Hea item othe		20a. Method of Dispositio		ST.	20b. P	lace of Dispo emetery, cre	sition (Nam	ne of)	Janua	ate	20c. Location	- City or T	own, State	
Ë	Page ient o int: If		1 St Burial 2 Cre 4 Donation 5 C			State Sacri	ed Hear	t of Je	esus (21, 2		Dundal	k,Mar	ryland	
Baltimore,	mit. partm porta y inju		21. Signature of Funeral	Service Licer	2590		10 2	2. Name an	d Addres	-	_	-	Dundalk			
m	Depa Impo any i		entho	uf (- (E	nne	lly	110 S	olle:	rs Po	int	Road, I	Dundalk	MD.	21222	
п	Physician /Medical Examiner		23a. Part1. Enter the dis- shock, or heart failu	ease, or com	plications that o	aused the death	n. Dono en	ter the mod	e of dying	, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between	
			Immediate Cause (Final disease or condition		He	Dati	()	/ -	1	051		of			Onset and Death	
杰			resulting in death) Due to (or as a consequence of):									7				
		_	Samentially list condition	15.	wn	Cause										
T		Examiner	if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	ate 4	Due to (or as a consequence of):											
<i>v</i>	and and I-tran	хап	that initiated events resulting in death) Last	1	c. Due to (or as a consequence of):											
8760,	cate be executed physician and the burial-transit	ical E	<u>a</u>													
	Attending Physicien: The law requires that the death certificate be executed refath. relath. ector: Atter this certificate has been signed by the attending physician and by the tuneral director, page 2 should be detached for use as the burial-transit				_ d									1		
Box 6	uires that the death certific signed by the attending f d be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent preg	nant		tcome of pregna		_					23d. D	ate of deliv	rery	
	death e atte d for	Cla	in the past 12 month 1 Ves 2 No		4☐Pregr	oirth 2 Fetal nant at time of d		⊒Ectopic pr ⊒ Other (sp						lonth	Day Year	
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	ss tha	by P	Part II. Other significant	/ -	contributing to d	eath but not resi	ulting in the u	inderlying c	ause give	n in Part I		23e. Did t	obacco use cor	ntribute to	the cause of death?	
ırd	w require been sig should b	ed	Aplas.	f, c	AN	e mai	य					1 🗀 '	Yes 2 No	3 ☐ Pro	bably 4 Unknown	
Records,	e law ra has be ge 2 sh	ple										24a. Was			opsy findings available ompletion of cause of	
Ĕ	The I	Completed											ormed? 2☐M6	death?	2 No	
Vital	icien: Th certificate rector, pag	Be (25. Was case referred to examiner?	medical							of Death	(Check only	one)			
$\frac{1}{2}$	hysia this c	၉	1☐Yes 2☑No		1	Inpatient 2	1			4 🗆 140			dence 6 XO		MOME HOME	
n o	ing P	.uo	27. Manner of Death 1 Natural 5	Pending		of Injury th, Day Year)	28b. Time o Injury		28c. Injury Work			28d. Describe	how injury occu	irred		
Division of	death,	Certification:	2 ☐ Accident 3 ☐ Suicide 6 ☐	investigatio Could not b	e Jee Blace	of Injune At he		M		/es 2 🗌		39f Location /	Stroot and Num	bor or Ou	rol Courte Alizabas	
Ž	or A after Direct in by	arti	4 Homicide	determined	build	of Injury - At ho ing, etc. (Specif	y) arm, st	reet, ractory	у, опісе		1	City or To	wn, State)	iber or Hui	al Route Number,	
	Hospitel of the said of the said the sa		29a. Certifier 1	Certifying Pl	hysician: To the	i heat of my kno	Madae dan	th Unnursed	et tha ten	e date an	id stage :	and dual to the	causals) and i	anner as	9194ad	
	Ho:	edical	(Check only Z 🔲 I	Medical Exa	miner: On the b	asis of examina ner stated.	tion and/or in	nvestigation	, in my op	oinion, dea	ith occurr	ed at the time,	date and place	, and due	to the cause(s)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and Me o	of certifier				290	c. License	number			29d. Date sign	ed (Month	, Day, Year)	
•			1 16	2 . 1	40			I	2003	388	7		01/20/	200	6	
	6		30. Name an address o	f person who	completed cau	se of death (Item	п 23а) (Туре	, Print)		,	-					
	9		Robert (Jicsi-	g. mi	n 3500	i Eac	ter	u	Ave	Kul	dimor.	, mo	217	124	
Pp.		ate	31. Date filed (Month, Da	ay, Year)	32. F	Registrar's Signa	iture	1.	-				/			
1	Regist	rar	JA	N 2 0	2006	Salvar .	1. 6	MALL	9							

DHMH 17 Rev 1/2001

Registrar

		•	For State Registrer	ate of Maryland	l / Depa <i>Cei</i>	artment of H	ealth an Death		giene	006	010	36
			Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of I	Death
	Physici /Medic		Darnell L. Brown					January	y 13	2006	6:05	\mathbf{p}^{M}
	Examin		4a. Facility Name (If not institution, give street	and number)		4b. City, Town, or	Location of D			ounty of Death	0.05	
			Rear of 219 A Blooms	bury Square		Annapo	lis		Anr	ne Arun	de1	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 I	Hrs. 8. Date of Bird	th	9 Right	place (State or	Foreign
	Director		220-84-2280	2115	35 Yrs.			Min. Dec 4	1970	Mar	yland	
	and *	}	Usuel Residence of Decedent 10a, State 10b, County	10c. City	Town or Lo	cation					10d. Inside Cit	v Limite
	hary!	ō	Maryland Anne Arun		napo						XXYes	
	28a-1	Directo	10e. Street and Number			10f. Zip Code			10a Citiza	n of What Cour		
	with a or	<u></u>	6 Dogwood Rd.			21403	2		-	ISA	iiu y :	
	ns 23	by Funeral		/as Decedent Ever in U.S	13. 1			? (Specify Yes or No		Race - Americ	can Indian	
	fter d	표	A	med Forces? ☐ Yes 2 X No	1	f Yes, specify Cuba	n, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	1.4.	Black, White,		
<u> </u>	ors e		- C	Yes, Give "" ear or Dates:		1 ☐ Yes XXNo	Specify:		St	pecify: Bla	ack	
Š	be filed within 72 hours efter deeth with the Maryland all Hygiene. de Hygiene. de other then "natural", or items 23s or 28s-f show of other then "natural", or items 23s or 28s-f show deent, the Medical Examinar must be notified at	Completed	15. Decedent's Educatio	n (stard)	16a. Deced	dent's Usual Occupa	ation		16b. Kind	of Business/In	dustry	
Ž	hin 7	ple	(Specify only highest grade con Elementary/Secondary (0-12)	ollege (1-4or 5+)	life.	Nind of work done d DO NOT use retired,	luring most of	working				
7	iw be an in the control of the contr	5	12th	0	La	ndscaper	<u> </u>		Eart	h Des:	ign	
פ	0 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Be (17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	Maiden Su	mame)		
Maryland 21215-0036	should be and Mental I s marked o	ဥ	George Brown				There	sa Snow	den			
ā		a ii	19a. Informant's Name/Relationship (Type, F					r Rural Route Numbe			Code)	
	1 and 2 Heelth tem 27 other tra		Monica Brown(Wife			T		apolis,				
altimore,	of H		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Remo	val from State	ace of Dispo mentery, cler	sition (Name of	9)	Date	20c. Loca	tion - City or To	own, State	
Ē	Pag ment ant: ury		4 □Donation 5 □ Other (Specify)		emete	_ +		20-06		polis	, Md.	
Bail	permit. Pages Department of I important: if its eny injury or of		21. Signature of Funeral Service Licensee		W	Name and Address	s of Facility	ns Mortu	arv,	P.A.		
	40 E = 9		1	moo483	8	21 West	St. A	nnapolis	Md.	2140	01	
Л	hysician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									
		disease or condition GWN HET WOWN (2) TO CHEST								Onset and D	eath	
	/Medical		resulting in death)	Due to (or as a conseque			-110	,				
	Examiner		Sequentially list conditions. b									
-		ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	эпсе от):								
	and trans	Examiner	that initiated events resulting in death) Last									
8760,	cate be executed physicien and the burial-transit			Due to (or as a conseque	ence or):							
	Attending Physician: The law requires that the death certificate be executed crosath. crosath. ector: After this certificate hes been signed by the ettending physicien and by the tuneral director, page 2 should be detached for use as the burial-transit	dicai	d									
9 X	eath certific ettending p	/Me	IF FEMALE: 23c II	yes, outcome of pregnan	ICV							
. Box	etten for u	ician/Me	in the past 12 months?	death 3	Ectopic pregnancy			23d. Date of delivery Month Day Year			ear ear	
o.	the d	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)									
<u> </u>	res that the de signed by the e I be detached f	by Phys	Part II. Other significant conditions contribu	ting to death but not resul	iting in the u	nderlying cause give	on in Part I.	23e. Did to	obacco use	contribute to ti	he cause of de	ath?
Vital Records,	uires sign ld be							101	res 2001	, No 3 ☐ Prob	ably 4 ∐U	nknown
ò	w require been sig should b	ete						242 1462			Carllana.	
ě	a hes ge 2	Completed						24a. Was autop		24b. Were auto prior to co death?	mpletion of ca	use of
a	hysician: The law his certificete hes t I director, page 2 s	မ C	OF Was seen intered to medical					12 Yes	2□No	death?	2□ No	
5	sicia certi irecto	00	25. Was case referred to medical examiner? HOSpi	tal:	700	othe Othe		Death Check only o			0	-
ō	Phy ir this aral d	٦.		Ba. Date of Injury	28b. Time of	IL SUIDOA	4 Nursir	ng Home 5 ☐ Resid			y) Scene	
o	ding th: After funer	ફ	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month Day Har)	F-21	A THOIR	? ∕es 2) €No		ECT ST			
Division of	Attendir death.	Hca	3 ☐ Suicide 6 ☐ Could not be 28	Be. Place of Injury - At hor	ne, farm, str	eet, factory, office	(fai)	28f Location /	Street and N	Jumber or Pur	al Route Numb	er,
á	al or i Dire	Certification:	Homicide determined	building, etc. (Specify)	STree.	t	((~)	Annance	vn, State)	219 A Blic	msiswy 19	une
	hours nera y fille		29a. Certifier 1 Certifying Physicie	n: To the best of my know	rledge, deati	n occurred at the tim	e, date and p	ace, and due to the	causa(s) an	id manner as s	tated.	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only XIX Medical Examiner:	On the basis of examination of the basis of examination of the basis of examination of the basis of the basis of the basis of the basis of examination of the basis of the basi	on and/or in	vestigation, in my op	inion, death o	occurred at the time,	date and pl	ace, and due to	the cause(s)	
	Tott withi Tott comp	ž	29b. Signature and title of certifier	1 1.1		29c. License	number		29d. Date s	signed (Month,	Day, Year)	
)	1) UN	1. 1/1	-		OCME		Janua	ry 14,	2006	
	1-1		30. Name and address of person who comple			Print)				,		
_	1		TACK N	. TIMIN, T)	111 Per	m Stre	et Baltim	ore.	Marvlar	d 2120	1
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire A	West of the second				J (41.	<u> </u>	
7	Registi	ar	JAN 2 0 2006	All Marie Do	and the second							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible Unpend item#23a,PII,2/,22a f.pen/E,GS2,2/6/06 II

للبابا	AN BLAC	K	Unpend item#23a,	PII, 27, 28a f	perM	. C852, 2	2/6/06	TT	oalth s	and M	lental L	lvaior			
			1 - For State Registrar	State of Mic	ai yiai i		rtificate			al iu iv	ieniai r		200	-	01037
		_	Hegistrar Decedent's Name (First, Middle, La	st)			illicati	5 01 L	Jeani		2. Date of	Reg. N	10C U U	U	3. Time of Death
1	Physici	an	Lillian M. Blac	-							JAN.		^{ay} 2008	ear	0900 A M
100	/Medic Examin						4b. City.	Town, or	Location o	of Death	OIMI		c. County of		0900 A
1	Examin	er	4a. Facility Name (If not institution, giv 9039 SLIGO CREEK	PARKWAY /	7611				SPRIM				MONTO		RY
	Funeral		Social Security Number 6. S			last birthday)	If Under		Il Under	24 Hrs.	8. Date of	Birth You	9	. Birtho	place (State or Foreign
1	Director		108-42-3911	□ M 2□ X F	51	Yrs.	Months	Days	Hours	Min.	8. Date of Month, Aug. I	,195	¥	Nev	York
34	pu .		Usual Residence of Decedent 10a. State 10b. County		10c Cin	y, Town or Lo	nantina							1	104 1-14-03/1-1-1
	ehor	ក		20.17				_						'	10d. Inside Çity Limits 1 ☐ Yes 2 ☐ No
	28a-f	ect	Maryland Montgome 10e. Street and Number	=1 y	נט	ilver :	101. Zip					10- (N		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any fujury or other traumatic event, I'm Medical Examinar must be notified at ADDS.	Completed by Funeral Director	9039 Sligo Creel	. Parkway	#611			0901					Citizen of Wh		•
	na 23	era	11. Marital Status	12. Was Decedent	Ever in U	S. 13.			spanic Orio	gin? (Spe	ecify Yes or		14. Race -		
G	or Rea	F	1 Never Married 2 Married	Armed Forces?	No	1	Was Deced if Yes, spec			, Puerto	Rican, etc.)			White,	
21215-0036	ral', c	by	3 ☐ Widowed 4 ☐ Wivorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	2E No	Specify:				Specify:	√hit	te
5-0	72 hc natu	etec	15. Decedent's E (Specify only highest gra			16a. Dece	dent's Usua kind of wor DO NOT us	I Occupa	ation during most	of worki	na	16b.	Kind of Busin	ness/Inc	dustry
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2	tygie tygie her t		17. Father's Name (First, Middle, Last			ble	ech 1	auio.			/Fire \$ \$400			ocne	
and	d be f	Be									_		en Surname)		
2	hould Mark Mark	ပ	George Black 19a. Informant's Name/Relationship (Type Print)		19h Maili	ng Address	(Street a	Jean		Lauba		or Town, St	nto Zim	Code
Maryland	od 2 s lth ar lth ar 27 is r trau		Georgette Stilwe			1							PA 1894		(0000)
ē,	r Hee		20a. Method of Disposition		20b. P	lace of Dispo emetery, cre					ate	_	Location - Ci		own, State
Baltimore,	Page ent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	-	view (1	an	20 20	05 Bs	1timo	20	Maryland
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death										Approximate Interval Between
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87	cate physi the l	edical		d										-	
9 X	leeth certific attending pl	/Me	IF FEMALE:	23c. If yes, outcome	of pregna	incv							201 0		
Вох	atter for L	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	Ectopic pro					4	23d. Date of Month		Day Year
P.O.	thet the de led by the a detached t	Physician/M	1 ☐ Yes 2 ☐ No 9 X Unknown	9□ Unknown											
	res thet signed b		Part II. Other significant conditions	ontributing to death b	ut not resu	ulting in the u	ınderlying ca	ause give	en in Part I.		23e. D	id tobacce	use contribu	ite to th	ne cause of death?
rds	w require been sig should b	Completed by	Atherosclerotic Card	iovascular D	isease)					1	☐ Yes	2 □ No 3	☐ Prob	ably 4 Unknown
ပ္သ	aw re s bec	plet									24a. W		24b. We	re auto	psy findings available
Ä	The lay	E O								-		utopsy erformed? s 2 1 1	dea	th?	mpletion of cause of 2□ No
ita	ysician: The is certificate hadirector, page	BeC	25. Was case relerred to medical examiner?						26. Place	of Death	(Check on		1.5	(100	
of Vital Records,	Attanding Physician: Ir death. ector: After this certifice by the funeral director, I	To	1 X Yes 2 No			ER/Outpatier	nt 3 DO	A Othe	er: 4 □ Nu	rsing Hor	me 5□R	esidence	6XXOther	(Specify	AT SCENE
Ē	ing P Viter t unera		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry Find y Year)	28b. Time o Injury	f Find 2	8c. Injury Work	at		28d. Descrit	oe how in	ury occurred		
Sio	tend leath tor: /	cat	2 Accident investigatio	1/10/00		9:00 A			Yes 21				ted drug		
Division	or Al	Certification:	4 Homicide determined	building, et	c. (Specify	v)	reet, lactory	, office			281. Locatio City or	n (Street Town, Sta	te) 9039	or Rura Slig	o Creek Pkwy,
_	pltei		29a. Certifier 1 ☐ Certifying PI	Found at			b coursed	at the tim	o data an						
	24 hos PFur etely	Medical	(Check only one) 2X Medical Example (Check only one)	niner: On the basis of and manner sta	examina	tion and/or in	vestigation,	in my og	pinion, deal	th occurr	ed at the tin	ne cause ne, date a	nd place, and	er as st due to	the cause(s)
	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral director.	Me	29b. Signature and title of certifier				29c	. License	number			29d. [ate signed (/	Month, i	Day, Year)
			I him him,	miD				0.0	M.E			J	AN. 1	9, 2	2006
			30. Name and address of person who	completed cause of d	eath (Item	1 23a) (Type,	Print)					1			
_			LING LI	mit	1	11 PEN	IN STR	EET,	BALT	IMOF	RE, MAR	YLAN	D 2120	1	
	Sta Registi		31. Date liled (Month, Day, Year)	32. Registr	ar's Signa	ture	Me a								

Frank W. Bury 06-00440 CT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of	Maryland /		artment of Hertificate of E			ene 006	01038
			Decedent's Name (First, Middle, Last	t)					2. Date of Death	1	3. Time of Death
	Physici /Media		Frank Warren Bu	У				_	January	18 2006	1:05 A ^M
	Examir		4a. Facility Name (If not institution, give		ber)		4b. City, Town, or I	ocation of Deatl	1	4c. County of Death	
			Franklin Square I 5. Social Security Number 6. S		. Age (In yrs. last	histhelau)	Rosedale	If Under 24 Hrs.	O Date of Dist	Baltimore	
	Funeral Director				60	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Pay, June 13,	1945 Mary	nplace (State or Foreign Lightry) "Land
	pu k		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	our or La	ention				101 1-11 00 11 1
	Aaryla f eho	ō	Maryland Baltimon	e	Esse		Cation				10d. Inside City Limits 1 ☐ Yes 2 No
	28a-	rect	10e. Street and Number		2000		10f, Zip Code		10	g. Citizen of What Cou	
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23s or 28s-f ehow aumatic event, the Medical Examiner must be morified at	Funeral Director	2539 Barrison Poir	nt Road			2122	21		U.S.A.	,
	r dea	uner	11. Marital Status	12. Was Deced	ent Ever in U.S. es?	13.	Was Decedent of His f Yes, specify Cuban	panic Origin? (S , Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	MOXYes 2 If Yes, Give Year or Dat			1 □ Yes XXNo	Specify:			ite
5-0036	2 hou	ted	15. Decedent's Ec	ucation			dent's Usual Occupat		1	6b. Kind of Business/I	
21215	e. Bn "n	Completed	(Specify only highest gra	de completed) College (1-	tor 5+)	(Give life. l	kind of work done du DO NOT use retired)	iring most of wor	king		,
7	filed wi Hygien other th	S		2	Lá	abore				an Manufac	turer
Maryland	ntal H	Be	17. Father's Name (First, Middle, Last) David Joseph Bury					18. Mother's Nam Selma Ro	se (First, Middle, M senfeld	aiden Sumame)	
2	should be f and Mental h marked or	٦	19a. Informant's Name/Relationship (7	ype, Print)	1:	9b. Mailir				City or Town, State, Zi	in Code)
ž	alth a alth a 27 is		Mary Jane Bury (Wi	fe)							yland 21221
ore	of He		20a. Method of Disposition 1 Derial 2XXCremation 3 D	Removal from St	0.000	of Dispo	sition (Name of natory or other place,)	Date 2	0c. Location - City or T	own, State
altimore,	Pag tment tant: i		4 ☐ Donation 5 ☐ Other (Specify)						Baltimore,	
Bal	permit. Pages 1 and 2 should by Deperment of Health and Menta Important: if Item 27 is marked eny Injury or other traumatic en 2002.		21. Signature of Fun-ral Service Hicen	500		22	Name and Address Bru 1407 Old E	izdzijnsk Lastern	i Funeral Avenue, E	Home, P.A ssex, Mary	land 21221
			23a. Part1. Enter the disease, or composhock, or neart failure. List only	olications that can	used the death. D						Approximate Interval Between
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	cuted nd ranslt	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C							
20	icate be executed physician and s the burial-transit	i Ex	resulting in death) Last	Due to (o	r as a consequenc	e of):					
58760,		edicai	•	d							
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	0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		h 2 ∏ Fetal dea nt at time of death		Ectopic pregnancy Other (specify)			Month	Day Year
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Ö	w require been si should I	iete	- VI PILLITE JUILI	TV EUSC					24a. Was an		
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Ta		BeC	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only one	□ No 1 Yes	2 ∐ No
<u>></u>	Physic this ce al dire	ပ္	XXYes 2 No	Hospital: 1 🗌 Ing		Outpatien	t 3 DOA Other	4 U Nursing H	ome 5□Residen	ce 6 Other (Speci	fy)
Division of	ding P h. After funera	Certification:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Month,	Injury 28b Day Year)	. Time of Injury	28c, Injury a Work?		28d. Describe how	injury occurred	
/ISI/	Attendi er death. ector: A by the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place o	f Injury - At home,	farm, stre		es 2 □No	28f. Location (Stre	et and Number or Run	al Route Number
á	s effer d is Direct at Direct	Serti	4 Homicide determined	building	, etc. (Specify)	,	, · , ·		City or Town,	State)	in robio rumbor.
	To the Hospital or Attending Physician: within 24 hours delet death: To the Funeral Director: After this certifical completely filled in by the funeral director;	Medicai	29a. Certifier 1 Certifying Physics (Check only one)	rsician: To the b iner: On the bas and manne	is of examination a	lge, death and/or inv	occurred at the time restigation, in my opin	, date and place, nion, death occur	and due to the cau	ise(s) and manner as s e and place, and due t	stated. o the cause(s)
	To th within To the compl	Me	29b. Signature and title of certifier				29c. License r	number	296	d. Date signed (Month,	Day, Year)
ì			Honet Prush	all, mi			OCME		.1,	anuary 18,	2006
10	119			11 .	of death (Item 23a	a) (Type, I			- 00	ALLICAL Y IU.	2000
0			31. Date filed (Month, Day, Year)	ithall, 1	NI) gistrar's Signature			nn Stree	t_Balti	nore, Maryl	and 21201
	Sta Registr		1.0.1.	006	Association of the state of the	4	and				

		1 - For State Registrar	State of Maryland /	Depa		lealth and	Mental Hyg	giene	06	01039
	- 1	Decedent's Name (First, Middle, Last))		tineate of i	Jean	2. Date of Dea	Reg. No.		2 Fire of Doort
Physicia /Medic		Janice	Ballou				Januar	9 17 a	Year 2 00 6	
Examin	er	4a. Facility Name (If not institution, give Baltimore Wash. Me	_		4b. City, Town, or		th	1	nty of Deat	
	\$ The second sec	5. Social Security Number 6. Sec		ninthday)	If Under 1 Year	Burnie	8. Date of Birth	h	O Die	rundel
Funeral Director			M 21XF 60	Yrs.	Months Days	Hours Min		2 ^Y 1945	Co	thplace (State or Foreign buntry) MD
land ow		10a. State 10b. County	10c. City, To	wn or Lo	cation					10d. Inside City Limits
NOTE BAILOUS BOUNDED TO THE MARY IN THE MARK IN THE MA	by Funeral Director	Maryland Anne Ar	undel			asadena				1 ☐ Yes 2 💢 No
with la or	ā	1473 West Cliff	Drive		10f. Zip Code	21122		10g. Citizen o	of What Co USA	•
death ms 23	era	11. Marital Status	12. Was Decedent Ever in U.S.	13. V			Specify Yes or No-	14. R		ncan Indian,
after or Item	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯 No		Was Decedent of H f Yes, specify Cuba		to Rican, etc.)	81	lack, White	e, etc.
ours a	d by	3 ☐ Widowed 4 💢 Divorced	If Yes, Give Year or Dates:	1	1 ☐ Yes 2 ☑ No	Specify:		Spec	ity: W	hite
OU 1215-0036 within 72 hours after ne.	ete	15. Decedent's Edu (Specify only highest grad	cation 16 e completed)	a. Deced	dent's Usual Occupi kind of work done of DO NOT use retired	ation during most of wo	rking	16b. Kind of	Business/	Industry
1210	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		oo not use retired omemaker) -		Иол	seho1	(d
d 2 d d 2 d d 2 d d 2 d d d d d d d d d	Be Completed	17. Father's Name (First, Middle, Last)		110	Jillelliakei	18. Mother's Na	me (First, Middle,			u
ylanc	To Be	Odin Klov	stad			Jane		ards	11110)	
Maryland Maryland of Should be file in and Mental Hy. 27 Is marked oth treumatic avent	} —	19a. Informant's Name/Relationship (Ty	pe, Print) 19	b. Mailin	g Address (Street a	and Number or R			n, State, 2	Zip Code)
ANICC imore, Ma Pages 1 and 2 s ment of Health an ent: If item 27 1s ury or other treu		John Klovstad (brother)		3 West Cl					
Ore, Not Health Item 27		20a. Method of Disposition	comot	of Dispos	sition (Name of natory or other place		Date	20c. Location		
Light Bags		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			emátory I	no loan	. 19	Baltim	ore,	Maryland
Baltimore, permit Pages 1a pormit Pages 1a popermit I dea eny Injury or othe one		21. Signature of Funeral Service Ligens	96	22	. Name and Addres	s of Facility		s Fune	ral F	lome, P.A.
		23a. Pan1. Enter the disease, or comp	cations that caused the death. Do	not ente					וש בו	Approximate
Physician		shock, or heart fallure. List only of Immediate Cause (Final	Emphysema							Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consequence	e of):						av years
Examiner		Sequentially list conditions).							/
₩ B €	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	e of):						
8760, sate be executed hysicien and the burial-transit	хаш	that initiated events resulting in death) Last	Due to (or as a consequence	a of):						
60, be ex	icai E			5 01).						
687 ficate physis the										
Box 66 eath certific attending pl	N/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy					23d. D	ate of deliv	verv
S, P.O. Bo	Physician/Med	in the past 12 months?	1 Live birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death		Ectopic pregnancy Other (specify)				onth	Day Year
at the by the stacher	hys	9 Unknown	9□ Unknown							
S tage	þ	Part II. Other significant conditions con	stributing to death but not resulting	in the un	derlying cause give	en in Part I.				the cause of death?
Cord w require been si	Completed						1 MY6	es 2□No	3 🗌 Pro	obably 4 Unknown
Pec e law has b	npje		-				24a. Was a autops	SV	prior to c	topsy findings available ompletion of cause of
Vital F	S						perform 1 ☐ Yes 2	2 No	death? 1 ☐ Yes	2□ No
on of Vital Reding Physicien: The Private this certificate he funeral director, page	Be	25. Was case referred to medical examiner?	ospital: 47/6-4444 AFF		Othe	NC:	ath (Check only on			
Of Phys or this aral di): To	27. Manner of Death	1 Uninpatient 2 LEH/C	Outpatient Time of	3 DUA	4 Nursing r	lome 5 Reside			ify)
ion onding F	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injury Work	? ∕es 2 □No		,,		
VÍSÍO Attendi	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office		28f. Location (St City or Town	reet and Num	iber or Ru	ral Route Number,
Ital or rs after all Die in led in	Cer		building, etc. (Opechy)				City of Yow	1, 31419)		
Divisio To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medicai	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	sician: To the best of my knowledger: On the basis of examination a and manner stated.	ge, death ind/or inv	occurred at the time restigation, in my op	e, date and place inion, death occu	e, and due to the ca arred at the time, da	ause(s) and mate and place	nanner as , and due	stated. to the cause(s)
To the Within To the complex	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date sign	ed (Month	. Day, Year)
		belete kass	ahun M.D	4	Doo	55973	7	lanuar	ru 1	7 2006
1		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, F	Print)					,
			11500 Suther	lana	d hill h	304 Si	luer Sp	Jus. su	MD	20904
Stat Registra		31. Date filed (Month, Pay Year) Q 2	32. Registrar's Signature	A	A REAL PROPERTY.					

DHMH 17 Rev 1/2001

ORIGINAL

Division of Vital Records, P.O. Box 68760.

		for State			ck Indelible in Department of Certificate of	Health and I		giene	gible. 06	01040
Physici	an	1. Decedent's Name (First, Middle, Last John E.	Bomhardt	· · · · · · · · · · · · · · · · · · ·	Certificate Of	Dealii	2. Date of Do	Day	2006	3. Time of Death
/Media		4a. Facility Name (If not institution, give			Ab City Tours	or Location of Deat	BANGA		inty of Death	6-00A M
Examir Funeral Director	ier	RALTIMORE WASHINGT 5. Social Security Number 6. S	TON MEDIC	e (In yrs. last t	MER GURU	BURULE I If Under 24 Hrs.	8 Date of Bi	Aur	VE AF	Pun PL place (State or Foreign ntry) MD
Maryland f show	o.	10a. State 10b. County	Arundel	10c. City, To	wn or Location	Pasadena				10d. Inside City Limits
with the la or 28a-	Director	10e. Street and Number 40 Luke Drive		1	10f. Zip Code	21122		10g. Citizen	of What Cou JSA	ntry?
leath	era	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Decedent of		pecify Ves or N		Race - Ameri	can Indian
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic evant, it is Medical Eadtr in mitting to collicat	by Funeral	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces? 1 TYPES 2 1 If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No		o Rican, etc.)		Black, White,	
hin 72 hc e. an "natu	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5		ia. Decedent's Usual Occu (Give kind of work don life. DO NOT use retir	upation e during most of wor ed)	rking	16b. Kind o	f Business/Ir	dustry
ed wij	Con	12	4		Engineer			West	<mark>i</mark> nghou	se
be filk tal Hy d oth evant	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar			name)	
1 Men narka	2	Emil Bomha				Anna		onough		
and 2 st lealth and m 27 is n			daughter)		9b. Mailing Address (Stree 11 Hub Court	, Millsbo	ro, DE_	19966		
Pages 1 nent of H int: if ita		20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from State	cemet	of Disposition (Name of tery, crematory or other pl		Date 23		on - City or To	
t. Pa rtmen rtant: njury		`4 □Donation 5 □ Other (Specifi	1	Meado	wridge Ceme	-	06			aryland
permi Depa Impo any ir		21. Signature of Funeral Service Licer	Haller	0/1		untain ko			uneral MD 21	Home, P.A. 122
Physician /Medical Examiner		23a. Par 1. Enter the disease, or comshock, or heart failure. Ist only immediate Cause (Final disease or condition resulting in death)	a Preumo	a consequence		ring, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
sate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· THROM	a consequence a consequence	STO PENIA					
The law requires that the death certificate Late has been signed by the attending physic page 2 should be detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal deal	th 3 Ectopic pregnant	су			Date of delive	ery Day Year
quires that n signed b	þ	Part II. Other significant conditions c	ontributing to death b	ut not resulting	in the underlying cause g	iven in Part 1.		obacco use co		he cause of death?
aiclan: The law requir certificate has been si irector, page 2 should	e Completed	25. Was case referred to medical					1 Yes	psy prmed/ 2 No	prior to co death?	psy findings available mpletion of cause of 2 No
aicia s cert irecto	o Be	examiner?	Hospital: 1 Inpatie	nt 2 - ED/C	Outpatient 3 DOA	26. Place of Dea				
iding Phy th. : After this funeral o	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Day		. Time of 28c. Injury Wo	ther: 4 \(\text{\text{Nursing H}}\) Lify at ork? \(\text{\text{Yes}} 2 \(\text{\text{No}}\) No	28d. Describe			у)
To the Hospiltal or Attending Physician: The twithin 24 hours after death. To the Funeral Diractor: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined		ury - At home, c. (Specify)	farm, street, factory, office		28f. Location (City or To	Street and Nu wn, State)	mber or Rura	I Route Number,
he Hospilt in 24 hous he Funera bletely fille	ledical C	29a. Certifier 1 Sertifying Ph 2 Medical Examone)	ysician: To the best of niner: On the basis of and manner sta	examination a	ge, death occurred at the tand/or investigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and date and plac	manner as s e, and due to	tated. the cause(s)
To t withi To ti	X	29b. Signature and tife of certifier	S		29c. Licen	se number		29d. Date sig	ned (Month,	Day, Year) 2006
*		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type, Print)	En Pan	mie W	W.	2106	4
Sta Registi		31. Date filed (Month, Dly, Fear)	A 7	ar's Signature	- 88 - 88					
HMH 17 Rev 1/2		JANZUZ	006	- JO.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #4a,5,perDVR, Inf., Soo, 1/4/Opartment of Department of Depart 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 200 19 JANUARY /Medical Facility Name (If not institution give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death If Under 24 Hrs. MONTGOMERY 5. Seojal Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 12M 2□F Days Hours Min. Director Yrs. 5/20/1 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "natural", or items 23s or 28s-f show other treumstic event, the Medical Examinar must be notified at 10d. Inside City Limits 1 Pes 2 No Director MONTGUMBR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 285 824 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PHYSICAL SCIENTIST 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be file Department of Heelth and Mental Hy Importent: if Item 27 is marked oth eny injury or other treumatic event <u>ance.</u> 18. Mother's Name (First, Middle, Maiden Surname) Be VIRGINIA BENNE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VALERIE BRYANT 834 COLLEGE PARKWAY RDCKVILLE, MID 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - dity or Town, State 20a. Method of Disposition Date 1 □ Burial 2 □ Cremation 3 □ Removal from State ANATOMY GIFTS REGI 9/06 HANDUER * 4 Donation 5 ☐ Other (Specify) 1 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ANATOMY GIFTS PLASTE TA COUNCIL 2:076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory an st, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner nenom 84 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit been signed by the attending physician and should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerei 1x Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELSAYYAL

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

ORIGINAL

32. Projistrar's Signature

2006

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	ertificate of			giene ()	6 01042
	Divi-i		1. Decedent's Name (First, Middle, Las	1)				2. Date of De	ath	3. Time of Death
	Physicia /Medic		Joan Marie Bartos					Janua		2006 1:25 PM
	Examin	er	4a. Facility Name (If not institution, give	street and number)	11.	4b. City, Town, o	r Location of I	Death	4c. County of	
			Cuyens Ne	essency	Home	Harre	de G	race	Hays	
	Funeral Director		114-24-4858	1X ☐ M 2X) F	ge (In yrs. last birthday 77 Yrs.	Months Days	If Under 24 Hours	Min. 8. Date of Bir (Month, Da 10 / 27 /	1928 N	9. Birthplace (State or Foreign Country) NEW YORK
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Mary f sho	ļo	MD Harford		Havre de	Guano				1X Yes 2 □ No
	r 28e	Director	10e. Street and Number		Thatte as	10f. Zip Code			10g. Citizen of Wh	nat Country?
	th with	al D	312 Strawberry La	ne		21078			USA	
	ema erra	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of H	lispanic Origin	n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race -	- American Indian,
36	or It	by Fu	1 Never Married 2 Married	1 □ Yes 2 📉 If Yes, Give	No	1 ☐ Yes 2 ☑ No	Specify:	1 00110 1 110211, 010.)	Specify:	White, etc.
Ö	hour:	d be	3 Widowed 4 Divorced	Year or Dates:	1 10- 5					White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or tema 23a or 28e-f ehow ha Madical Exartil at rival be notilled at	Completed	15. Decedent's Ed (Specify only highest grades)	de completed)	(Giv	edent's Usual Occup e <i>kind of work d</i> one DO NOT use retired	durina most o	of working	16b. Kind of Busi	ness/Industry
212	l with jiene. r thar	omo	Elementary/Secondary (0-12)	College (1-4or 4 ULATS	5+)	hematicia	,		U.S. Go	vernment
b	be filed stal Hygi ed other event, I	Be C	17. Father's Name (First, Middle, Last)					s Name (First, Middle,		
da	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M.	To	Frank Bartos				Anna	Nemecek		
lar	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygene. If Item 27 is marked other than "naturat", or itema 23a or 28e-f show or other traumatic event, it is healtest Esser'il at rosal be notified at	1 4	19a. Informant's Name/Relationship (7					or Rural Route Numbe		
e)	1 and tealth om 27 ther to		Katherine Lundstr	.om- Cousi	1.0	Bladesvill	le Rd.,	Morgantou		
Baltimore, Maryland	or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		, ,	osition (Name of ematory or other place		Date	20c. Location - C	
ΙŧΪ	it. Pa intmer intant injury		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License 			ris & Co.		1/17/06		ster, PA
Ba	permit. Pages 1 and 2 Department of Health s Important; if Item 27 is any Injury or other tra		A LOLLE W	50-14	8 N	itchell-S	mith"F	uneral Hon	ne, P.A.	110 01076
			23a. Part1. Enter the disease, or comp	lications that cause	d the death. Do not en	ter the mode of dyin	<i>LLNGLON</i> ng, such as ca	ı, Havre di	e Grace,	Approximate
	Physician		Immediate Cause (Final	one cause on each I	ine.	Arten				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a	a consequence of):	-110000	1 1113	scale		> 10 yrs
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	D #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		а сонзедиелсе ог):					
	and I-tran	хаш	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):					
8760,	icate be executed physician and s the burial-transit	alE			a consequence or,					
687	ficate p phys	edlcal		d						
Вох	leath certific attending p	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		G-			23d. Date	of delivery
<u> </u>	death	Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregnant a		□Ectopic pregnancy □ Other (specify) _	<u></u>		Month	
P.0.	that the de led by the a detached t	hys	9 Unknowń	9∐Unknown						
Division of Vital Records, I	88 20 8	by	Part II. Other significant conditions of Delay d		out not resulting in the	1 1	en in Part I.	23e. Did to		ute to the cause of death? Probably 4 Unknown
CO	s been si	Completed	Ü	1		1		24a. Was	an 24b. We	ire autopsy findings available
Re	The lav	шо							rmed? pric	or to completion of cause of ath?
ita		Bec	25. Was case referred to medical				26. Place of	1 ☐ Yes f Death (Check only o		lYes 2□ No
<u>></u>	S S S	70	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpati	ent 2□ER/Outpatie	ent 3 DOA	er: 4 Nursi	ing Home 5 Resid	dence 6 Other	(Specify)
n o	ding P. h. After t		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time (of 28c. Injun Worl	v at		now injury occurred	
Sic	tend death tor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be	00 01 (1)			Yes 2 □ No			
<u>></u>	after of Direction by	Certification;	4 Homicide determined	building, et	jury - At home, farm, si tc. (Specify)	treet, factory, office		28f. Location (S City or Tou	Street and Number vn, State)	or Rural Route Number,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Phy	rsician: To the best	of my knowledge, dea	th occurred at the time	ne date and c	place, and due to the	cause(s) and mann	ar ac etatad
	ne Ho	edical	(Check only 2 Medical Exam	iner: On the basis of and manner st	of examination and/or in	nvestigation, in my of	pinion, death	occurred at the time,	date and place, and	d due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License			29d. Date signed (Month, Day, Year)
•	0		1 Winan	1. WD		b 3	2609		1/13/06	,
1	0		30. Name and address of person who o	ompleted cause of	death (Item 23a) (Type	, Print)	1040			
L			am main Mil	hemmo	1106 Jevs	lution S'	+ 4	arre De	pau M.	31078
	Sta Registr	_	31. Date filed (Month, Day, Year) JAN 2 0 2		rar's Signature	1 . 10 .	•			
			13/519 /. 1/	1 1 PA 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2						

ORIGINAL

	For State Registrar	State of Maryl		partment of l ertificate of			giene 00	5 01043
cian lical	Decedent's Name (First, Middle, La LINDA SUE	BITZELBEF	RGER			2. Date of Dea Month	214 J	ear 6.599 N
iner il r		e Hospital	Centoryrs. last birthda 54 Yrs.	r Ro		rs. 8. Date of Birt	ball 951	Death MOCC Birthplace (State or Foreig
_ _ _	Usual Residence of Decedent 10a. State 10b. County MD BAI	TIMORE 10c.	. City, Town or		ROSEDALE			10d. Inside City Limit:
I Director	10e. Street and Number 4812 BRIGHT LEA	F COURT		10f. Zip Code	21237		10g. Citizen of Wh	at Country?
by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes ZXXNo If Yes, Give Year or Dates:	n U.S. 1	3. Was Decedent of If Yes, specify Cut		(Specify Yes or No- erto Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. WHITE
Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation	(G)	cedent's Usual Occu ve kind of work done b. DO NOT use retire SENIOR UI	during most of w		16b. Kind of Busin	ness/Industry
To Be C	17. Father's Name (First, Middle, Last OLIVER H.	WRATCHFORE)		18. Mother's N BETT	ame (First, Middle, Y D.		ONALD)
	19a. Informant's Name/Relationship DAWN SYNDER/DAU			illing Address (Stree KING AVE	and Number or I	Rural Route Numbe	r, City or Town, St. D 21237	ate, Zip Code)
	20a. Method of Disposition 1	Removal from State	b. Place of Dis cemetery, c Sardens	position (Name of rematory or other pla of Faith	Cem 1-1	Date 9-2006	20c. Location - Ci	
	21. Signature of Funeral School Lice	\$88		22. Name and Addr 1211 CHES			DALE FUNI DALE, MD	ERAL HOME 21237
al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a condition of the cond	sequence of):					Onset and Death
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1 □ Yes 2 M No 9 □ Unknown	_d. 23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death	B Ectopic pregnanc Other (specify)	у		23d. Date of Month	f delivery Day Year
ρ	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause gr	ven in Part I.	,		ite to the cause of death?
Completed	COPD					24a. Was a autop: perform 1 🗆 Yes	sy prio med? dea	re autopsy findings available r to completion of cause of th? Yes 2 \(\square\) No
To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	≥ E R/Outpati	ent 3□ DOA Ott		eath Check only or Home 5 Resid		Cooch
Certification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year	28b. Time Injury	of 28c Inju Wo M 1		28d. Describe hi	ow injury occurred	
	4 Homicide determined	building, etc. (Spe	9cify)			City or Tow	n, State)	or Rural Route Number,
Medical	29a. Certifier (Check only one) 2 Medical Example of certifier	nysician: To the best of my niner: On the basis of exam and manner stated.	ination and/or	investigation, in my	opinion, death occ	curred at the time, d	ate and place, and	due to the cause(s)
	Dund Dr	Come (MA)		N 1	7 9 4	/.	IAAA /C) no (i) (ia
tate	30. Name and address o person of the state o	mpleted cause of death (I) MD GOOD 32, Registrar's Signature	Item 23a) (Typ	e, Print) Klin Sque	ire Diziv	z Baltur	nove, MD	21237
trar	JAN 2 0 20	106 And	the state of					

				1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death
				1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
_		Physici /Medio		Robert Hamilton Bauer January 15, 2006 14:26
		Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
				Upper Chesapeake Medical Center Bel Air Harford
		Funeral		5. Social Security Number 6. Sex 181-16-5548 7. Age (In yrs. last birthday) 85 Yrs. 1 Months Days Hours Min. 1 Days Hours Min. 1 Month, Day, Year) 1 Month Days 1 G. 10 20 1 D
		Director		Usual Residence of Decedent
		yland yland		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
		ith the Marylar or 28a-f ahow oe notified at	Stor	Maryland Anne Arundel Baltimore 1 Dyes 2 1 No
		or 28	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
		death with the Maryland ms 23a or 28a-f ahow rmat be notified at	ral	410 5th Avenue 21225 USA
		er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
	36	rs afte	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1 □ Yes 2 □ No Specify: Specify: Specify: White
	21215-0036	72 hours after natural', or Ite		15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
9	215	within 72 ene. than "na he Media	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired)
63	212	d with giene er the	E O	2 Production Control Can Manufacturing
7		be filed tal Hygi d other event, I	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
	yla	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, The Ma	L _O	Martin George Bauer Jr. Cora Adele Leydich
0	altimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 Is merked other than "natural", or items 23e or 28e-1 ahov any injury or other traumatic event, the Nedical Evantinat must be redified any injury or other traumatic.		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
115/06	6,	1 and 2 Health tem 27		Bette Bauer / Wife 410 5th Ave., Baltimore, MD 21225 20a. Method of Disposition Date 20c Location - City of Town State
10	ğ	if ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery, crematory or other place)
	Ξ	it. Partmer rtent rtent njury		*4 Donation *5 Other (Specify) Hilltop Service Corp. 1-17-06 Towson, Maryland 21. Signature of Funeral Service Licensee.
	Ba	permit. Page Department Importent: If any injury or once.		McCollas Funeral Home, P.A.
				1317 Cokesbury Rd., Abingdon, MD 21009
	1 6			23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Immediate Cause (Final
		Pnysician /Medical		disease or condition resulting in death) A Hinns De to (or as a consequence of):
		Examiner		Hallo I di la dimarcal la sancia
		9 45	Je.	Sequentially list conditions, if any, reading to immediate cause. Enter Undertying Cause (Disease or injury
d		cuted nd ransit	Examiner	trat initiated events
10	0	e exe ian a urial-t		resulting in death) Last Due to (or as a consequence of):
ري	876	cate be executed ohysician and the burial-transit	Physiclan/Medical	d
9	9 X	leath certifica attending ph I for use as th	Med	IF FEMALE:
=	Во	death c	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1
#	o	0 0 2	ysic	1 Yes 2 No 9 Unknown 9 Unknown Month Day Year
4	۹.	requires that the de een signed by the a nould be detached f		Part II. Other significant conditions contributing to death but not r s ti g in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
5	ds	uires sign ld be	d by	Tdispullic lulmonan + 10.88 1 1 Yes 2 No 3 Probably 4 Donknown
2			lete	24a. Was an 24b. Were autopsy findings available
0	Re	The faw	ompleted	autopsy prior to completion of cause of performed?
a			e C	1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)
	_ <	S o D	0 B	examiner? 1 Yes 2 No
P		ding Ph h. After thi funeral	nc:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work? 28d. Describe how injury occurred Work?
Ξ	Sio	Attending or death. sctor: After by the fune	catic	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No
30	Division	il or Attendater deati	ertification;	3 Suicide 4 Homicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
-		spital or ours afte serat Dis filled in	0	
00		the Hospital or nin 24 hours afte the Funeral Dir npletely filled in I	edical	29a. Certifier (Check only one) Check only one) Check only one) Check only one) Check only one)
H		To the Hospital within 24 hours a To the Funeral Completely filled i	Med	29b. Signature and little of Confier 29d. Date signed (Month, Day, Year)
		F > F 0		
				3). Name and address of person who completed cause of death (Item 23a) Type, Pfint)
14.			1	Koren Lorresti 1308 Busies Center May & dewood MD 21040
10		Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature
		Registr	ar	JAN 2 U ZUUD ALLES AND

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Clara Elizabeth Bradley January 17, 2006 4:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien - Bel Air Bel Air Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 215-09-0649 1 ☐ M 2X F 89 Yrs. Director Feb. 9, 1916 Maryland Usual Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiene. Important: If item 27 is markad other than "natural", or items 23a or 28a-f show any injury or other treumatic event. The Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 USA 2 Patterson Mill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 Yes 2 No Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Agricultural Elementary/Secondary (0-12) College (1-4or 5+) Farming Equipment Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hannah Ellen George William Parker Everitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Patterson Mill Rd., Bel Air, MD 21015 William B. Milway/son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State st. Mary's Epis. Cem. Jan. 19, 2006 Abingdon, MD 1 Burial 2 □ Cremation 3 □ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ASPIRATION PNEUMONA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Each index mg Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate ba executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, CEREBROVASCULAR ACCIDENT HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown CARDIAC ARRHYTHMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 Yes 2 X No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 12 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🕱 Ño 27. Manner of Death e Hospitel or Attending Pl 24 hours after death. e Funerei Director: Atter ti 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 2 D45344 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 622 S. UNION AVE, HAVRE DE GRACE, MO 21078 MD DHANJANI 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 0 2006 Registrar

			Please Ty 1 - State Amend item#PII,27	rpe or Print in Black State of Maryland / De ,28a-f, perME,g859,94			-	_	01046
					erillicate of Dea		Reg 2. Date of Death	, No.	3. Time of Death
	Physicia	an	Decedent's Name (First, Middle, Last)	2			Month	Day Yeer	4
	/Medic	_	RAYMOND	BUFFALOE			JANUAR		1-51 PM
	Examin		4a. Facility Name (If not institution, give str	eet and number)	4b. City, Town, or Loca	ation of Death		4c. County of Death	
			Rock Glen Nursing	Center	Baltimo				
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthd		Inder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthp	lace (State or Foreign unk
	Director		018-56-2080	41 Yrs			July 15,	1964	· unk
	9		Usual Residence of Decedent	110 00 7					0d. Inside City Limits
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	a-fs	Ş	MD	В	altimore				1√2 Yes 2 □ No
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	h wi	a C	10 N. Rock Glen Ro	oad	21229			USA	
	deat	Funeral		. Was Decedent Ever in U.S.	 Was Decedent of Hispan If Yes, specify Cuban, Me 	nic Origin? (Spec	cify Yes or No-	14. Race - Americ Black, White,	
0	after or ite	F	1 X Never Married 2 ☐ Married	1 ☐Yes 2 ☐ No		pecify:	10411, 010.)	C===/6	
215-0036	72 hours after death with the Maryland naturelt, or items 23s or 28s-f show disal Examber must be notified at	Ď	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 21 No Sp	ecily.		Specify: bla	ck
Ą	2 ho	Completed	15. Decedent's Educa	ition 16a. De	ecedent's Usual Occupation Give kind of work done during fe. DO NOT use retired)	a most of workin	unk 16	6b. Kind of Business/Inc	dustry unk
Ë	· ·	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	e. DO NOT use retired)	g most or women	9		
	filed within Hygiene. •ther then *	E	unk unl						
0	be filed within 72 hours after death with the Marylan Hygiene. do ther than "naturelt, or Items 23a or 28a-f show event, I'te Medical Examenae must be notified at	Be C	17. Father's Name (First, Middle, Last)		unk 18.1	Mother's Name	(First, Middle, Ma	aiden Surname)	unk
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	1 and Health em 27 ther t		20a. Method of Disposition	20b. Place of D	isposition (Name of			oc. Location - City or To	
ਠੁ	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rei	moval from State	crematory or other place)				
Baltimore,	permit. Pages Department of Importent: If i any injury or once.		' 4 ☐ Donation 5 ☑ Other (Specify)			P. 100			
ğ	epar opor opor op in		21. Signature of Funeral Service Licenses	de Ditector	State Anatomy	y Board	655 W.	Baltimore S	Street
	ಷ್ಟ್ರತ್ವಾಡ		June 16		Baltimore, MI	$\frac{0}{21201}$			
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death. Do not cause on each line.	enter the mode of dying, su	ich as cardiac or	respiratory arres	it,	Approximate Interval Between Onset and Death
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87	w requires that the death certificate been signed by the attending phys should be detached for use as the		d.				APPROVED OF		
×	ding	/Me	IF FEMALE: 23	c. If yes, outcome of pregnancy		CERTIFI	U	23d. Date of delive	arv.
Box 68	ath c	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy			Month	Day Year
<u>.</u>	e de the a	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)				
Р. О	d by detach	F.	Part II. Other significant conditions conti	in the standards but not condition in the	- underhing sound gues is	Dort I	23e Did toba	cco use contribute to the	ne cause of death?
Ś	gne bed	Completed by Physician/Medi	Λ						
ב	en si	ed	PNEUMONIA	HYPOGLY	Hypoth	hemnia.	I Tes	2 No 3 Prob	ably 4 Unknown
ပ္ပ	s be	plet	LIEPATIC E	NCEPHALOP	ATHY		24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
æ	he la e ha age	E		STROINTESTI		DING	perform	ed? death?	2 No
Division of Vital Records,	n: T ificat or, p	Ö	25. Was case referred to medical	2.1 KO 111 1 CZ 1.1			Check onl one		
Ē	sicia	8	avaminar?	espital: 1 ☐ Inpatient 2 ☐ ER/Outp				ce 6 ☐Other (Specif	v)
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S:	teath tor: the	cal	2XXAccident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, larm	ILOWII	л е	81 Location (Stre	a tameratur et and Number or Rura	A Route Number.
	or Al fter of pirec n by	Certification;	4 Homicide determined	building, etc. (Specify)	i, street, ractory, office		City or Town,	State) unknown,	Baltimore
	res a			unknown			City, Mary		
	To the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	edical	29a. Certifier 1 Certifying Physi (Check only 2 Medicel Exemine	cian: To the best of my knowledge, our control to be basis of examination and/	death occurred at the time, do or investigation, in my opinion	late and place, a n, death occurre	and due to the cau ad at the time, dat	use(s) and manner as s e and place, and due to	tated. the cause(s)
	To the P within 24 To the P complete	ed	one)	and manner stated	100 11			d Data sire of (Manth	Day Vass)
	To To	Σ	29b. Signature and title of certifier	(MI)	DI 23		29	d. Date signed (Month,	1
			* Kanal 102	aufmo	N 82	02		112/2006)
			30. Name and address of person who con			0		1/12/2006 Maryland	
			Romal K. Dang M	1.D. 3455, Wilk	ens Ave	Baltin	love,	Maryland	21229
	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signature	No No.		7	J	
	Regist		JAN 2 0 2006	Miller of A	2345				

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			1 - For State Registrar	State of M	aryland / D	epartment of F Certificate of	lealth and N <i>Death</i>		iene 006	01047
	Physici	an	1. Decedent's Name (First, Middle, La				-	2. Date of Deat Month		3. Time of Death
	/Medi	cal		IEL BRI				JAN	11 200	6 15:12bm
	Examir	ıer	4a. Facility Name (If not institution, given Buttimore VA Red	le street and number)	ded ca	Balt	r Location of Death	l	4c. County of Dea	ath
	Funeral		5. Social Security Number 6. 8	9	e (In yrs. last birth		If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Bi	rthplace (State or Foreign Country)
L	Director		448-10-3902 Usual Residence of Decedent	1 M 2□F	87 Y	rs. Months Days	Hours Min.	Apr 12,	1918 0	klahoma
	yland		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	e Mar 3a-f sl	Director	MD		Ba1	timore				1- Yes 2□No
	with the	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	Country?
	death ms 23	eral	1849 S. Charles S	12. Was Decedent	Ever in U.S.	13. Was Decedent of H	21230 Ispanic Origin? (Sc	pecify Yes or No-	USA 14. Race - Am	erican Indian
92	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show Ita Mailcal Exir il at mast Le natified at	by Funeral	1 Never Married 2 Married	Amed Forces? 1 X Yes 2 ☐ I If Yes, Give	40	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Puerto	Rican, etc.)	Black, Wh	ite, etc.
21215-0036	hours tural',		3 XWidowed 4 ☐ Divorced 15. Decedent's E	Year or Dates:			1111		Specify: W	
215	nin 72 In "na Medic	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed)		Decedent's Usual Occup (Give kind of work done i life. DO NOT use retired	durina most of work	_{sing} unk	6b. Kind of Business	s/Industry unk
21	ed with	Com	1	College (1-4or 5 nk	+)					
and	t be fill ntal H ed oth	Be	17. Father's Name (First, Middle, Last)		unk	18. Mother's Nam	e (First, Middle, M	laiden Sumame)	unk
Maryland	should nd Me mark mark	To	19a. Informant's Name/Relationship (Type, Print)	19b. l	Mailing Address (Street	and Number or Bur	al Bouta Number	City or Tourn State	Zin Code)
	and 2 alth a 127 is ar trau		VAMC			N. Greene				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show with highly or other traumatic avent, if a Macifiel Exercities in as I be notified at ODGe.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	200. Flace of L	Disposition (Name of crematory or other place		Date 2	0c. Location - City or	Town, State
<u>=</u>	it. Pagirtment rtant: njury		* 4 □ Donation 5 ☑ Other (Specif) in state						
Ва	Depa Depa Impo any It		21. Signature of Funeral Service Ucer	Wade,	etor	State Anato Baltimore,	omy Board	655 W.	Baltimore	Street
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death. Do no	ot enter the mode of dyin	g, such as cardiac		st,	Approximate Interval Between
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68760	tificate ig phys as the	edicai		d						
XOX	leath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth	of pregnancy	3 Ectopic pregnancy			23d. Date of de	livery
O. B	at the dea by the at tached fo	ysici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□ Unknown		5 Other (specify)			Month	Day Year
Ţ.	that the by detact	y Ph	Part II. Other significant conditions of	ontributing to death bu	it not resulting in t	he underlying cause give	n in Part I.	23e. Did toba	icco use contribute to	the cause of death?
Records,	en sign	Completed by	CAD					1 ☐ Yes	2 ⊠ No 3□Pr	robably 4 Unknown
eco	law requias been	plet	CHF					24a. Was an autopsy	24b. Were au	utopsy findings available completion of cause of
		Con	Dementia					performe	ed? death?	2 No
Vital	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Othe		(Check only one,		
סר	ig Physicar this neral di	n: To	27. Manner of Death	28a. Date of Injur (Month, Day	nt 2 ER/Outp	ne of 28c. Injury	4 Vursing Ho	me 5 Residen 28d. Describe how	ce 6 □Other (Spe injury occurred	cify)
S	or Attanding Fafter death. Diractor: After in by the funerial	catio	1 ★ Natural 5 Pending 2 Accident investigation	1	Year) Inju		r res 2 □ No			
Division	al or Attand after death It Diractor: , d in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home, fam . <i>(Specify)</i>	n, street, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
_	e Hospital 24 hours a e Funaral etely filled	a Ce	29a. Certifier 1 Certifying Ph	ysician: To the best of	f mv knowledge. d	death occurred at the tim	e date and place	and due to the cau	so(s) and manner as	stated
	m 00	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examination and/	or investigation, in my op	inion, death occurr	ed at the time, date	e and place, and due	to the cause(s)
	To the within To the comple	Σ	29b. Signature and title of certifier			29c. License		290	I. Date signed (Monti	
		-	20 None and address of assessment	nompleted	- Ab (1)	05	6508		Jan	11 2006
			3900 Lock	Rowen	ath (Item 23a) (Ty	(pe, Print) X/	Noron	MDS	2121	£
	Stat		31. Date filed (Month, Day, Year)	32. Registra	's Signature	. 6° k	Mer			
	Registra	ir	JAN 2 0 2006	Brigary J	7 190					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** Jan. 18, 2006 12:35 A M Charles Edgar Cowley, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 3380 Hooper Delight Road New Windsor Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. | Min. | Dec. 16, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral ₩**M 2□ F 50 Yrs. Maryland 219-58-4627 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "neturel", or itame 23s or 28s-f show the Medical Examiner must be notified at Funeral Director 1 ☐ Yes 2 No MDCarroll New Windsor 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3380 Hooper Delight Road 21776 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Baltimore Public Works 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy important: if Item 27 is marked oth any jury or other treumatic event page. 18. Mother's Name (First, Middle, Maiden Sumame) Be Edgar Samuel Cowley Barbara Gertrude Newton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 3380 Hooper Delight Road New Windsor, MD Deborah Ann Cowley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 \ Burial 2 \ Cremation 3 \ Removal from State 4 \ Donation 5 \ Other (Specify) Druid Ridge Cemetery Jan. 20,2006 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Road Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Yours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a nonsequence of): Examiner physicien and s the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an hes autopsy performed? Yes 2 No this certificate 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation ofter death Director: / 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide ro the Hospitel within 24 hours e To the Funerei pelli 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 19, 2006 110051924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marchaster MD 2110 Heibert J. Hendaron S. MD 2973March 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 7:45a M 18,2006 January Patricia Α. Cooper /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 13217 Birdale Ave. Middle River Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State Country) | Months | Days | Hours | Min. | Dec. 31, 1940 | Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 ☐ M 2 🔀 F 65 Yrs Director 219-38-0427 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "netural", or Items 23a or 28e-f ehow tre Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No MDBaltimore Middle River Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13217 Birdale Ave. 21220 USA filed within 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Booker Bettie Rutter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13217 Birdale Ave. Baltimore MD 21220 Robert Cooper /husband ... Pages 1 ar ...artment of H' ...portent: if it any injury or 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State /21/06 Baltimore MD HollyHillCemetery 4 ☐ Donation 5 ☐ Other (Specify) Departi Departi Importi any ni 22. Name and Address of Facility 21. Signature of Funeral Service Licensee ConnellyFuneralHomeofEssex 23a. Part 1. Enter the disease, or computations that caused the death. Deficienter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List physic cause on each line. Immediate Cause (Final disease or condition resulting in death) Masoive hemorrha **Physician** no minut /Medical minute Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit 101 Metastatic Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospitei or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home SX Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 027220 06 Mason 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 492 NAOMI P. CUTZEK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AEM 06-00401 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Casey Lee Cummings State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician Casey Lyle Cummings 10:10 P^M 2006 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cheverly Prince George's Hospital Prince George's If Under 1 Year Months Days 8. Date of Birth Month, Day, Year) Feb 2, 1977 9. Birthplace (State or Foreign Country) Washington DC 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 10 M 2□F Days Min. Hours 220 15 6962 28 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Worle Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla ment of Health and Mental Hygiene.

Internation of Heam 27 le marked other than "neturel", or Iteme 23a or 28a-1 ehov ant; If Item 27 le marked other than "neturel", or Iteme 25a or 28a-1 ehov ary or other traumatic event. If a Medical Examinar must be notified at 1 ☐ Yes X No Directo Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11895 Duley Station Rd 20772 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 💥 o If Yes, Give Year or Dates: Specify White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Heating and Air Condit 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Donald Lee Cummings Cherry Lee Spicer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11895 Duley StationRd, Upper Marlboro, MD 20772 Donald Cummings (father) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of H Importent: If Its eny Injury or ot 900. 1 Burial 2x Cremation 3 R 4 Donation 5 Othe (Specify) 3 Removal from State Lee Crematory Jan 17, 2006 Clinton, Maryland 21. Signature Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 10146 Alexandria Ferry Road, Clinton, MD 20735 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Multiple injunes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to luminodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, ed by the ettending detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of Y Yes 1 Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Yes 2□ No Other: ٩ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 28d. Describe how injury occurred driver of money 27. Manner of Death 28b. Time of Injury Certification; 1 Natural eache in collision efter death. 1 ☐ Yes 2 No 2 Accident 3 Suicide investigation 5:03 115/06 6 Could not be determined Location (Street and Number or Rur | Rouse Number, Sity or Turni, State) 28e. Place of Injury - At home, farm, street, factory, office filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours e To the Funeral E 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME outhall, mi January 16, 2006

State Registrar

tameka E. 31. Date filed (Month, Day, Year)

32. Registrar's Signature

0 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Southall, MD

200

ORIGINAL

111 Penn Street Baltimore, Maryland 21201

		•	1 - For State Registrar	State of Marylan		rtment of Health and tificate of Death		iene 006	01051
	° Physici		1. Decedent's Name (First, Middle, Las Robert	Edward	Cons	tantine	2. Date of Deat January	Day Vee	3. Time of Death 1:35PM M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or Location of De Riverdale		4c. County of Death Prince Geo	rge's
40	Funeral Director		Social Security Number 6. S		last birthday) Yrs.	If Under 1 Year If Under 24 H Months Days Hours Mi	n. Nate of Birth (Month, Day, March 2	.1	place (State or Foreign
	e Maryland 8a-f show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince G		y,TownorLo Capita	1 Heights			0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with th	al Dire	10e. Street and Number 505 Suffolk: Ave.	nue #315		10f. Zip Code 20743	10	og. Citizen of What Cour U.S.A	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Evantiner must be refilled at Once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ ₩oroced	12. Was Decedent Ever in U. Armed Forces? 1 MYes 2 □ No 194 If Yes, Give Year or Dates: 194	3-	Vas Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Pu ☐ Yes 2 ☒ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
Baltimore, Maryland 21215-0036	within 72 ho ene. then "natur re Medical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th	ucation	16a. Deced	ent's Usual Occupation kind of work done during most of w O NOT use retired)	orking	16b. Kind of Business/Inc	•
and 2	ld be filed ental Hygi ked othar ic evant, I	To Be Co	17. Father's Name (First, Middle, Last) Charles Consta	ntine			ame (First, Middle, A	Maiden Sumame)	
Mary	nd 2 shou ilth and M 27 is mar	-	19a. Informant's Name/Relationship (7 John S. Curran, S			g Address (Street and Number or Pinegrove Drive			
imore,	Pages 1 a nent of Hez ant: If itam ury or otha		20a. Method of Disposition 1	Removal from State	emetery, cren	Veterans Cem.	C	20c. Location - City or To he1tenham ,	Maryland
Balt	permit. Departr Imports any inj		21. Signature of Funeral Service Licem	h 10015	3 6	633 Old Alexand	ia Ferry		n, MD20735
	Pnysician /Medical Examiner	L	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	ne cause on each line.	va Lo uence of):	ar the mode of dying, such as card	3 4000 97		Approximate Interval Between Onset and Death
8760, <	cate be executed physician and the burial-transit	dical Examiner	Tary, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence)					
.O. Box 6	The taw requires that the death certificate be exacuted ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
ords, P	w requires that been signed t should be deta	ted by PI	Part II. Other significant conditions of	The Carrilo	vasco	lar Diseast		acco use contribute to the	
Vital Records,	ysicien: The taw r is certificate has be director, page 2 sh		Cenebral	twettve lu.		seasz	24a. Was ar autopsy perform 1 Yes 2	24b. Were auto- prior to con- death?	psy findings available inpletion of cause of 2 No
	sicien: The scertificate lirector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ED/Outpation	011	eath (Check only one	nce 6 🗍 Other (Specify	
Division of	는 다 F	tlon: To	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe ho		7
Divis	To the Hospital or Attanding Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely illed in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	eet, factory, office	28f. Location (Str. City or Town	reet and Number or Rura , State)	l Route Number,
	ha Hospit n 24 hours he Funera	Medical (29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	vsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the time, date and pla estigation, in my opinion, death oc	ce, and due to the ca curred at the time, da	use(s) and manner as st ite and place, and due to	ated. the cause(s)
	, ,, ,	M	29b. Signature and title of certifier	well-	2	29c. License number		Od. Date signed (Month,	
	721		30. Nam and address of person who c	ompleted cause of death (Item	23a) (Type, I	Da185 relusburg Rd	Matte-	1/4 Med 2	0781
j.	Sta Registr		31. Date filed (Month, Day, Year)	32, Registrar's Signa	ture	See soing rea	IMW	W.C / - PA	- ~//

	State of Maryland / Department of Health and Mental Hygiene 1 - State Amend item#30, perDVR, C851, 1/20.06 TT Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) LILLIAN CHREST State of Maryland / Department of Health and Mental Hygiene Reg. No. 1 0 5 2 1 Decedent's Name (First, Middle, Last) Day Year 12:49 P M									
b				st)	CHREST			2. Date of Death Month	Day Year	3. Time of Death 12:49 P
	/Medic Examin		4a. Facility Name (If not institution, given ST., JOSEPH HOS			4b. City, Town, o	TOWSON		4c. County of Death	IMORE
2 ²	Funeral Director		Social Security Number 6. 8		o (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 7-30-192	9 Birth	place (State or Foreign intry) ARYLAND
	D		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	ecation		, 30 132		10d. Inside City Limits
	Maryla	tor		TIMORE	iso. only, found of Ed	Nation:	TOWSON			1 ☐ Yes 2 No
	with the	Director	10e. Street and Number 1120 GYPSY LANE	MEST		10f. Zip Code	21286	. 10g.	Citizen of What Co.	,
9	within 72 hours after death with the Maryland isene. Then "natural", or Items 23a or 28s-1 show the Madical Examiner must be notified at	/ Funeral	11. Marital Status 1 □ Never Married 2 Married	12. Was Decedent & Armed Forces? 1 Yes 2 If Yes, Give	t-		dispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	ican Indian,
5-003	72 hours natural', dical Exe	eted by	3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gr	Year or Dates: ducation	16a. Dece	dent's Usual Occup		ng 16t	b. Kind of Business/li	
2121	e filed within 72 al Hygiene. other then "nai	Completed	Elementary/Secondary (0-12)	College (1-4or 5	life.	BOOKKEEP	d)		ACCOUNT	TING
Maryland 21215-0036	id be filed ental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, Last FRANK RU	ZYLO			18. Mother's Name	(First, Middle, Mai		
	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship CHARLES L. CHRE			ng Address (Street) GYPSY L		al Route Number, Ca TOWSO	ity or Town, State, Zi	p Code) 1286
Baltimore,	permit. Pages 1 and Depertment of Heall Important: if item 2 eny injury or other once.	1 0	20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci			natory or other plac			E. Location - City or T	
Balti	permit. Depertm Imports eny inju		21. Signature of Funeral Service Lice	nsee			ss of Facility CVA		LE FUNERA ALE, MD	L HOME 21237
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	To the within 2 To the complet	Me	29b. Signature and title of certifier	She	Ph. M.D.	29c. Licens	se number	29d.	Date signed (Month)	Day, Year)
-	4		30. Name and address of person who							
2	Sta	ate	Robert B. Stoltz Si	32. Registra	ar's Signature	•				
	Registi	rar	20	2006	20 D. A.	sole				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [1- State Registrar Amend item #23a Per PHY g85 Per 1920 1960 in eath 2. Date of Death 3. Time of Death Day Month Year **Physician** Ruby Irene Cales 13, 10:15 PM^M 2006 /Medical January 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2√2 F 232-44-1916 78 Director Jan. 8, 1928 West Virginia Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow 1 ☐ Yes 2 No Baltimore Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7300 Park Drive 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'naturel', or iteme 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: white ģ 3 ☐ Widowed 4 🎗 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Board of Education 12 Bus Driver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) and Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic everages. Thomas Lee Woods Bessie (u/k) Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce N. Purcell, daughter 1305 Belle Meade Road, Fallston, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Hilltop Service Corp. 1/16/2006 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland

23a. Parti. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Namen Cancer **Physician** disease or condition resulting in death) 2 days /Medical Due to (or as a consequence of) Examiner حرنتانا Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 9 No 1 TYes 2 4 No Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 UNO 1 Umpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 1 Yes 2 HO 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 [Learlifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d, Date signed (Month, Dev. Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mesapeake Orive Bel Air, mp 21014 NESREEN KURTOM 500

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State

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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and manner stated.	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
039071	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ashkan Bahrani, MD 602 S. Atwood Rd., Bel Air, MD 21014	
Ashkan Bahrani, MD 602 S. Atwood Rd., Bel Air, MD 21014 State 31. Date filed (Month, Day, Year) 32, Registrar's Signature	
Registrar JAN 2 0 2006	

			·	_ FOI	partment of Health and Nertificate of Death		ene 2.006	01055
			(F)	Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
		Physici /Medic		Daniel B. Curtis, Sr.		January	15, 2006	8:05 AM
	100	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
				Gilchrist Center	Towson V) If Under 1 Year If Under 24 Hrs.	O Date of Birth	Baltimo	
		Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last binthda $213-32-6758$ 18 M $2\Box F$ 70 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day,) April 18	Year) 1935	place (State or Foreign ntry) Maryland
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		ith the Marylar or 28e-f show se notified at	cto	MD n/a Baltimo:	re City			1 ☐ Yes 2 🔀 No
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JAM	9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Madical Examinational be notified at 80ce.	/ Funeral Director	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify: 	Rican, etc.)	14. Race - Ameri Black, White, Specify: Uh:	etc.
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			1 - For State Registrar	State of Marylan	nd / Depa	artme	nt of H				ZIIIIh	01056
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9000	ural', or Ite	d by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	,	1 🗆 Yes	2 X) No	Specify:	Puerto Rican,		Black, Wh	White
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Baltimore,	nit. Pages artment of the ortent: If Ite injury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifical Signature ☐ Fabrial S	Removal from State Mo.	cemetery, cren reland	matory or Mem	other plac Par	k 01	/21/20	06 Ba		Maryland
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	10		30. Name and address of person who Dr. Penelopesson 31. Date filed (Month, Day, Year)	completed cause of death (Iter 277, 900 Frau 32. Registrar's Signa 2006	n 23a) (Type,	Print)	arei) sive	Balt	Limore	(m)	21237
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State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Clarence Eugene Duvall 1620 Januar /Medical 4e. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1-Air Rehab -leal 0 . Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 217-22-2700 Days Hours Min. Director Maryland Aug. Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location f ehow 10d. Inside City Limits r 28a-f ehow Md. Harford Bel Air 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or U.S.A. 410 E. MacPhail Road 21014 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritaf Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: white 3 ☐ Widowed 4 ♣ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ed other than " Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. bond underwriter insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental F 27 is marked of traumatic ever Pages 1 and 2 should be Ruth Cromwell Clarence Duvall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 ie any injury or other trau 11957 Hemlock Road, Lusby, Md. 20657 Joanne Duvall/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) St. Mary's Ch. Cem. 1/19/2006 Pylesville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. MacPhail Road, Bel Air, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Dementia fmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) detached Records, P.O. 9 Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 3 ☐ Probably 4 ☐ Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 ☐ Yes 2 ☐ No 1 Yes of Vital the funeral director, Be 25. Was case referred to medical 26. Place of Death | Check only one Other: Nursing Home 5 Residence 6 Other (Specify) Hospitaf: 1 ☐ Yes 2 ☐ No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred Division 5 Pending 1 Natural Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō To the Hospital 29a. Certifier ertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintened as section.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ange MOIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2006 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner HEFORI SA 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F 6742 Director 12-03-Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits If itam 27 is marked other than "natural", or itams 23a or 28a-f show or other traumatic event, the Medical Exercit at mast be redified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 8m 27 Is marked othar than "natural", or Ita 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working interpretation of the control o 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Sural Route Number, City or Town, State, Zip Code) Important: If Itam 27 Is. any injury or other train-114 215 PHED W. E 1. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) EVANS TUNERY 22. Name and Address of Facility FURNS 21. Signature of Funeral Service Licensee INDERAL CHNITE - DEL AIR. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ARTERIOSCLEROTIC ARDIOVASCULAR disease or condition resulting in death) ten years /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, Dualto (or as a consequence of) d any, leaving to immedicause. Enter Underlying Cause (Disease or injury that initiated events use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 1 Yes 2 🟋 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 1 🗌 Yes 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA Certification: To 2 X No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29b. Signature and title of certifier

29a. Certifier

(Check only

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10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene 106

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		(30. Name and address of person wh	o completed cause of death (Item	n 23a) (Type,	Print)				
5 Dr. Mark Diamond, 9000 Franklin Square Drive, Baltimore, MD 21237		5			d, 9000 Frank	lin Sc	Luare	Drive,	Baltim	ore, Mi) 21237
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item / per th g851 1-23-06 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 2006 Peggy Jan 14, Davis 1:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Bradford Oaks Nursing Home Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 442 24 2229 8. Date of Birth (Month, Day, Year) Sept 1, 1926 9. Birthplace (State or Foreign Funeral Months Days Hours XXM 2□F 79 McCIIud, OK Yrs. Sept Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or iteme 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Clinton Maryland Prince George's Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4510 Natahala Drive United States 20735 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 TVN If Yes, Give TX Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite, any injury or other traumatic event, the Medical Examinat 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 💓 o Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Paralegal U.S. Justice Dept 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Sanders Haskell Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4510 Natahala Drive, Clinton, MD 20735 Lawrence Davis (husband) 20b. Place of Disposition (Name of commetery, crematory or other place) Jan 19, 2006 20a Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State Clinton, Maryland Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d la Alexandria Ferry Road, Clinton, MD 20735 moizeH 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Altheimeri **Physician** noun disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, 1 any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto (or as a nonsequence of) Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai ed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ate has been signi page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 ☐ Yes 2 No After this certification Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death | Check only one examiner' Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 24 hours after death. Funeral Director: Al 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ca completely (Check only one) To the within 2 29b. Signature and title of confit 29c. License number 29d. Date signed (Month, Dav. Year) Cenany JANUARY 16 ZOUG 735206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Tanner, M.D. 11701 Livingston Road #101, Fort Washington, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

De la Carlo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middlet Last) Year Month **Physician** 1205 PM enuary 2006 amo 00 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b City, Town, or Location of Death **Examiner** OWN IMOVE nda a thwes Nov If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F Days March16, 1932 Pennsylvania 182-50-7235 73 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10h Count 10a State or 28a-f shov other treumetic event, the Medical Exercit er tours Le notified at 1 Yes 2 No Directo Baltimore Catonsville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe United States 21228 1525 Adams View Road Items 23a Pagas 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "neturel", or Items 23. Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Not Self Supporting Dependent 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Nellie Dwilinski Solomon Diamonds 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Lillian Sheehan, Sister 146 Harmony Way, Centreville, Maryland 21617 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ō permit. Page Department of Importent: If any injury or once. Holy Trinity Cemetery Jan.21,2006 Bear Creek, PA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Robert Bednarski Funeral Hove M01113 27 Park Avenue, Wilkes-Barre, PA 18702 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Day SDIVA disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit The law requires that the death certificate be axecuted Due to (or as a consequence of) Box 68760. the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No for 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown ģ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an autopsy performed?

1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has to page 2 s certificate Division of Vital Hospital or Attending Physician: Be (25. Was case referred to medical examiner? 26. Place of Death Check onl. one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Impatient 3 DOA 2 1 🗌 Yes 2 ER/Outpatient this 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Date of Injun After t Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide within 24 hours a

To the Funerel C (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical the 29c. License number 29b. Signature and title of certifier 62912 191 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NWHC 5401 HJUBI

State Registrar 31. Date filed (Month, Day, Year) JAN 2

0 2006

32. Registrar's Signature

		-	For State Registrar	State of Ma	yland		artment of h		nd Mer		ene 00	01063
	Physici /Medic		1. Decedent's Name (First, Middle, La	Defazio	(5	Senio	r)			Date of Death Month Jak		3. Time of Death
	Examin		4a. Facility Name (If not institution, giv UNIVERSITY OF MARK	e street and number) yland Medic	ial Ce	nter	4b. City, Town, o Batti	more			4c. County of E	
· ·	Funeral Director		5. Social Security Number 6. S 193–14–3697	7. Age	(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days		Min.	Date of Birth (Month, Day, ept.19	,1923 Pe	Birthplace (State or Foreign Country) nnsylvania
	yland		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Ba-fell	ector	Maryland		Ba	ltimo					li,	1 Nes 2 No
	with t	Dir	600 Light Street				10f. Zip Code 21230			10	g. Citizen of Wha United	,
	death	nera	11. Marital Status	12. Was Decedent Ev Armed Forces?		. 13.	Was Decedent of I	Hispanic Origin	n? (Specify	Yes or No-	14. Race - /	American Indian, Vhite, etc.
036	filed within 72 hours after death with the Maryland Hygiens. Niter then "natural", or Iteme 23e or 28e-f ehow ent, the Mazical Exzrimer must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 \(\) No lf Yes, Give Year or Dates:	WII		1 ☐ Yes 21 No		T donto i not	ari, 6(0.)	Specify:	White
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and 2	ontal Hyginal	To Be C	17. Father's Name (First, Middle, Last, Thomas DeFazio)				18. Mother's			laiden Sumame)	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department if item 27 is marked other than "natural," or iteme 23a or 28a-1 show any injury or other traumatic event, the Maclical Exercities must be notified at ance.	ř	19a. Informant's Name/Relationship (Thomas DeFazio,		,		ng Address (Street	and Number	or Rural R	oute Number,		
ore,	ges 1 and of Heelt if item 2 or other 1		20a. Method of Disposition 1 Burial 2 Cremation 3		20b. Pla	ice of Dispo netery, crer	sition (Name of matory or other pla	ice)	Date	2	Oc. Location - City	or Town, State
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100	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line				_			st,	Approximate Interval Between Onset and Death 5 hours
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	10		30. Name and address of person who 22 S. GYEEN	e St Bat	timo	re, r	MD 21	201				
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		•	For State Registrar	State of Maryla		artment of H <i>rtificate of L</i>		ental Hygie Reg	4000	01064
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В	Funeral Director		5. Social Security Number 6. Sex 215-09-9473 1□	M 2 XF 7. Age (In y)rs	i. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yo 6-30-191	ear) Co	hplace (State or Foreign ountry) CYLAND
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or L	ocation				10d. Inside City Limits
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	death ms 23	neral		12. Was Decedent Ever in	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		city Yes or No-	14. Race - Ame	ncan Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Exactinal main the notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □Yes 2 XNo If Yes, Give Year or Dates:		1 Yes, specify Cuba 1 Yes 2 X No	n, мехісап, Риепо і Specify:	Rican, etc.)	Black, Whit	
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	buld be filled with Mental Hygiene. arked other that atic event, Ire.	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			
Maryland	and Men Is marke	2	GEORGE ULRIC 19a. Informant's Name/Relationship (Type		19b. Maili	ing Address (Street a	VERONIC and Number or Rura		NKIEWICZ)	Zip Code)
	t and 2 Health a em 27 le		VERONICA ROMIG/DA			35TH STRI		EDALE, ME	21237	
nore	85 = 9		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, cre	osition (Name of matory or other place LL CEMETE	Θ)		c. Location - City or	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		2	2. Name and Addres	s of Facility CVAC	TH/ROSEDA	MIDDLE RI	L HOME
			23a. Part1. Enter the disease, or compli	cations that caused the dea			GO AVENUE g, such as cardiac of			Approximate
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	1 \		30. Name and address of person who co	ensun	Ave	nue!	saltimo	re M	arvano	1 21227
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DHMH 17 Rev 1/2001

Registrar

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	Funeral Director	8	5. Social Security Number 212 - 00 - 4819 Usual Residence of Decedent	7. Age (In)	Yrs. last birthday,	If Under 1 Year Months Days		8. Date of Bir Month, Di	1918 /	Birthptace (State or Foreign Country)
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Maryland	should be and Mental ie marked o	To	19a. Informant's Name/Relationship	Type, Print)	19b. Maili	na Address (Street	and Number or Ru	ral Boute Numb	UNK er, City or Tgwn, Sta	nown te Zin Code)
Baltimore, Ma	Pages 1 and 2 nent of Health au int: if item 27 ie iry or other trau		20a. Method of Disposition 1 Valurial 2 Cremation 3 4 Donation 5 Other (Specification 2)	Persion 200	0 20 Dispo	Crosse	Pointe	Ct. Date	20c. Location - City	rgdun my
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, vo	Physician /Medical Examiner	ai Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a const.) Due to (or as a const.) Due to (or as a const.)	sequence of):			or respiratory a	rrest,	Approximate Interval Between Onset and Death
P.O. Box 687	The law requires that the death certificate be ex lie hes been signed by the attending physicien page 2 should be detached for use as the burial	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions c	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3[of death 5[☐Ectopic pregnanc☐ Other (specify)	,	23e. Did t	23d. Date of Month	delivery Day Year
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_			25 Was sans interest to medical					1 Tes	rmed? deat 200 1 □	to completion of cause of h? Yes 2 \sum No
of Vital	Physician: this certific al director.	To Be	25. Was case referred to medicat examiner? 1 □ Yes 2 No	Hospital: 1 ☐ Inpatient 2	ER/Outpatier		4 Nursing H		one) dence 6 Other (S	Specify) HOSPICE
Division of	To the Hospital or Attending Physician: which 24 hours letter death as the certification to the Funeral Director. After this certification the funeral director, to the funeral director.	Certification:	27. Manner of Death Natural 5 Pending investigation 3 Suicide 4 Homicide Getermined		t home, farm, str	M 1□	ry at rk? Yes 2 □ No		Street and Number o	r Rural Route Number,
	Hospita 4 hours Funerel tely filled	Medical C	29a. Certifier Check only one) Certifying Ph	ysician: To the best of my hiner: On the basis of exam	rnowledge, death ination and/or in	h occurred at the till vestigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the within 7 To the comple	Mec	29b. Signature and tille of certifier	and manner stated.		29c. Licens			29d. Date signed (M	
			30. Name and address of person who	completed cause of death (I	tem 23a) (Tyne	Print)	3725		Danuary il	,2006
0.	ľV		Taria Markad 31. Date filed (Month, Day, Year)	2300 Dulano	yValle	yld, T	Timonium	MD	2109.3	
	Sta Registr	ar	JAN 2 0 2	32. Registrar's Sig	A A	artis				
DHI	MH 17 Rev 1/20	001			0					

JANUARY 13, 2006

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WILLIAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 21 per fh 8851 1-20-06 vt. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** JANUARY 18, 2006 GEORGE **ECONOMAS** 10:15A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 1226 NARCISSUS AVENUE ROSEDALE BALTIMORE Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Min. Months 1**⊠**M 2□F 85 Yrs. 5-25-1920 IOWA 481-16-1811 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at ROSEDALE 1 Yes 2 No MD BALTIMORE Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1226 NARCISSUS AVENUE 21237 U.S.A. 23a Funeral death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1X]Yes 2□No If Yes, Give Year or Dates: 1943–46 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐ No Specify. WHITE δ 3 Widowed 4 ☐ Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. important: If Item 27 le marked other than any Injury or other traumatic event, Ite Mealth once. Elementary/Secondary (0-12) College (1-4or 5+) 12 CHEF GREEK RESTURANT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **GEORGE ECONOMAS** APHRODITE (GIOVANIS) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GEORGE ECONOMAS/ NEPHEW 1226 NARCISSUS AVENUE ROSEDALE MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State GREEK ORTHODOX CEM. 11-23-2006 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee Sharon Unitas per fh/dvr 1211 CHESACO AVENUE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death — 2 WG dioc Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner gry Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical for use as IF FEMALE: 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Records, halla semia 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 Pending investigation 1 Yes 2 No after death. 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D-2(221 BRN 709. E NASBEM 32. Paistrar's Signature ... 31. Date filed (Month, Day, Year) State

Registrar

06-00372 B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Unpend item#1 23a PIT 27 pen/F 0852.2/15/06 IT State of Maryland / Department of Health and Mental Hygiene) NORMAN C. EVANS 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Norman C. Evans 2. Date of Death 3. Time of Death ^{Day} 2006 JAN. CHRISTOPHER **Physician** EVANS, JR. 14, 2030 P M /Medical Facility Name (If not institution, give street and number) 8017 EDGEWATER AVENUE 4b. City Joseph Accation of Death *C. County of Death BALTIMORE Examiner | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 11-28-1929 7. Age (In yrs. last birthday) 5. Social Security Number 212–26–8182 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □XM 2 □ F 76 Yrs. MARYLAND Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County or 28e-f show other traumatic event, the Medical Examinar must be notified at MD BALTIMORE 1 Yes 2 No ROSEDALE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8017 EDGEWATER AVENUE 21237 U.S.A. or Items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: KOREAN Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Pages 1 end 2 should be filed within 72 hours after tent of Health end Mental Hygiene. Int: If itsm 27 is marked other than "nsturs!", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Completed by Specify: WHITE 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STEEL WORKER 12 BETHLEHAM STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NORMAN C. EVANS, SR. EUGENEIA (BENA) ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ERIC WARTHEN/ NEPHEW 204 PATAPSCO AVENUE ROSEDALE, MD 21237 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removat from State permit. Page Depertment of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH CEM. 1-21-2006 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hypertensive atherosclerotic cardiovascular disease resutting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown peen 24b. Were autopsy findings available prior to completion of cause of death?

✓ Ses 2 □ No 24a. Was an certificete has t irector, page 2 s autopsy performed? Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{XOther} \) Other (Specify) \(\text{AT} \) SCENE ို Yes 2 No 2 ER/Outpatient the funerel dir 3□ DOA this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 X Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident after death Director; 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai within 24 ho To the Fund completely f (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E JAN. 15, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Min. 31)(K NI

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Will. 111 PENN STREET, BALTIMORE, MARYLAND 21201
32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registamend Item #23P11 G852 2/27/06 Smificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^D2006 **Physician** Carl Otto Garver Jan. 18, 7:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Continuum Care Sykesville Carroll If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**∑**M 2□ F Yrs. Director 218-24-9627 1928 Maryland Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo MD Carroll Woodbine 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 7332 John Pickett Road 21797 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No þ 3 ☐ Widowed 4 X Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "na any injury or other traumatic avent. The Wedge 2008. College (1-4or 5+) Elementary/Secondary (0-12) 8 Farmer His farm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Carl Edward Garber Martha Louise Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4102 Eyre Court Westminster, Duane Garver Son MD21157 20b. Place of Disposition (Name of cametery, crematory or other place)
Evergreen Memorial
Gardens
23 Name and Address 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Jan. 21, 2006 Finksburg, MD 21. Signature of Funeral Service . Name and Address of Facility Burrier-Queen Funeral Home & Crematory, 1212 W. Old Liberty Road Winfield, M 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonor r nysician Znecks. /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Box 68760. attending physician ician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached Records, P.O. Physi 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 2 No 1 ☐ Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 Yes 2 No 4 Vursing Home 5 Residence 6 Other (Specify) P 3 DOA 27. Many r of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t or Attanding Patter death. Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral C To tha Hospital 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 18,2000 1000599943 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

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31. Date filed (Month, Day, Year)

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06-0258 B.K.S BEVERLY JO GRAHAM

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			State Registrar		Certifica	ate of Death	Reg	Z U U D	01000
	Physicia	an	1. Decedent's Name (First, Middle, Last)	T. C	ca laa		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	DEVELLEY As Facility Name (If not institution gives	JO () I	raham.	ty, Town, or Location of Dea	JAN. 6	, 2006 4c. County of Death	11:45 A ^M
	Examin	er	4a Fecility Name (If not institution, give)s 5101 RIVER ROAD AP	r. 817	B	ÉTHESDA		MONTGOME	
F	Funeral		5. Social Security Number 6. Sex	M 201F 7. Age (In yrs.	/ / Month	der 1 Year If Under 24 Hi s Days Hours Mi		9. Birth	place (State or Foreign
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yland	Mow #		10a. State 10b. County	10c. Ci	ty, Town or Location	t ^			10d. Inside City Limits
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5-0036 72 hours after death with the Maryland	a or 2	Funeral Director	10e. Street and Number	1 at 811	7 101.	Zip Code	10g	Citizen of What Cou	intry?
death	me 23	nera	11. Marital Status	2. Was Decedent Ever in C	J.S. 13. Was De	cedent of Hispanic Origin? pecify Cuban, Mexican, Pue	Specify Yes or No-	14. Race · Amer	
36 after	or its	y Fu	1 Never Married 2 Married	Armed Forces?. 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		2 No Specify:	eno nican, etc.)	Black, White	etc.
21215-0036 ad within 72 hours af	turef.	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ		16a Decedent's II	Sual Occupation	16	b. Kind of Business/Ir	odustor
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	Hygiene ther the int, the h	Соп	12	5	Disak	oled		N/A.	
and	Mental H arked otl atic even) Be	17. Father's Name (First, Middle, Last)	ham		18. Mother's N	ame (First, Middle, Ma	den Surname)	
E & S	ut of Health and Mental Hygiene. If item 27 is marked other than "neturel; or iteme 23a or 28a-f show or other treumatic event, the Medical Examiner must be notified at	2	19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailing Addre	ess (Street and Number or I	Rural Route Number, C	ity or Town, State, Zi	p Code)
C 7	ealth a n 27 io		Botty J. Klein-C	craham	25624 L	shitworth	DR., Mac	eca CA.	93038.
	or of		20a. Method of Disposition 1 □ Burial 2 ▼Cremation 3 □ R	emoval from State	Place of Disposition (fi	r other place)	-1 -	c. Location - City or T	
	Depertment Importent: I eny injury o once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligense	154	410S FUNERLY	TICHAPEL- 11	18/06 TOREST HI	DRESTHI	LLMO
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			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only on	ations that caused the dear	th. Do not enter the m	ode of dying, such as cardi	ac or respiratory arrest		Approximate Interval 8etween
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	Medical aminer		resulting in death)	Due to (or as a consec	quence of):				
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8760,	physician end s the burial-transit		resulting in death) Last	Due to (or as a consec	quence of):				
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Box eath cert	ettending pl	an/M	230. Was decedent pregnant	Bc. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		prechancy		23d. Date of deliv	,
O. Be dea	the ett hed fo	sicia	in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	4☐Pregnant at time of o				Month	Day Year
P.O.	igned by the be detached		Part II. Other significant conditions con	tributing to death but not res	sulting in the underlyin	g cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
rds quires	ים יט	ed by	Probletes re	litus			1 ☐ Yes	2 No 3 Pro	bably 4 Unknown
of Vital Records, Physician: The law requires t	2 38	Completed	Rend Disease	,			24a. Was an autopsy	24b. Were auto	opsy findings available empletion of cause of
<u>ت</u> ا	cete h page	Соп					performe Yes 2	d? deam?	2□ No
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Vision	death. ctor: After / the funer	atlo	2 Accident 5 Pending investigation	(Month, Day Year)	Injury M	vvonk? 1 ☐ Yes 2 ☐ No			
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Division To the Hospital or Attending			29a. Certifier 1 ☐ Certifying Phys	ician: To the best of my kno	owledge, death occurr	ed at the time, date and place	ce, and due to the caus	e(s) and manner as	stated.
he Ho	within 24 hours To the Funeral completely filled	edical	(Check only 2 Medical Examin	er: On the basis of examination and manner stated.	ation and/or investigat	on, in my opinion, death oc	curred at the time, date	and place, and due t	o the cause(s)
Tot	To t com	Σ	29b. Signature and title of certifier	1110		9c. License number O.C.M.E		Date signed (Month, JAN. 11,	
•	1	t	. O Clorke	WV)		0.0.11.11		TINY LL,	
	(c)		30. Name and address of person who co			REET, BALTIM	ORE, MARYLAI	ID 21201	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. UU6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Vaar **Physician** Evelvn Eugenie Goring January 11. 2006 2030 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Fort Washington Eospital Ft. Washington Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 6. Sex **Funeral** 1 □ M 2 🗓 F Yrs. 82 150-44-7461 Director March West Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Heath and Mantal Hygiana. Important: if Item 27 is marked other than "natural", or items 28 or 28a-f show any injury or other traumatic event, its Medical Examinar maint in matter. 10a Stete 10b. County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes ŽÍŽÍ No Funeral Director Prince George's Maryland Ft. Washington 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12419 Asbury Drive 20744 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No 3altimore, Maryland 21215-0020 Specify: Black Specify: Be Completed by 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) LPN Hospital 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Jonathan Benn Veroner Franklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Derek Knights (Nephew) 12419 Asbury Drive Ft. Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jan. 21 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lee Crematory 2006 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Service Licenses 6633 Old Alexandria Ferry Road Clinton, MD20735 MOIZEH 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** immediate Cause (Final disease or condition resulting in death) /Medical a. Atheroscleratic andinomala Disec Examiner Completed by Physician/Medical Examiner é re mo or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attanding physician and Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 1 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred : Aftar t 1 Natural 5 Pending investigation ours after death.

Neral Director: Af death. 1 Tyes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, efc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature end title of certifier 29d. Date signed (Month, Day, Yeer) 01-13-2016 D45765 m Sin livings for ad #101, ff was by to MD 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 11701

DHMH 16 Rev 6/95

State Registrar 32. Registrer's Signature

Sida Rous, ma.

31. Dete filed (Month, Dey, Year)

		1 - For State Registrar	State of Maryla		rtificate of D		R	eg, No.	010/1
Physi		1. Decedent's Name (First, Middle, Last) Jeanne Goss					2. Date of Dear Month 01-14	Day Year 4-2006	3. Time of Death 02:10 pt
) Exam	dical niner	4a. Facility Name (If not institution, give s Manor Care Potom			4b. City, Town, or Potomac	r Location of Death		4c. County of Dea	
Funera Directo		5. Social Security Number 6. Sex 407-34-1158		rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) 0I-10-	Year) 9. Bir	Thely Thplace (State or Foreign Ountry) Tucky
e Maryland a-f ehow	ctor	Usual Residence of Decedent		City, Town or Lo	ocation				10d. fnside City Limits 1 ☐ Yes 2 X No
ath with the 23a or 28	Funeral Director	10e. Street and Number 10714 Potomac Ten	nis Lane			20854		0g. Citizen of What C	ountry?
yiand 21213-UU36 Juld be filed within 72 hours after death with the Maryland Mental Hygiene. arked other then "natural; or items 23s or 28s-f ehow atte event, the Modical Expressor in ust be notified at	ğ	3 ⊠ Widowed 4 □ Divorced	 Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 		Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2🛣 No		cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.
TZT3-U	Completed	15. Decedent's Educ (Specify only highest grade			a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired) Property Manager		ng	16b. Kind of Business Property	Management
Maryland 21213-UU36 d 2 should be filed within 72 hours af th and Mental Hygiene. ?? Is marked other then "natural", or traumatic event, the Medical Exam	To Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, i	Maiden Surname)	
Mar d 2 sho d 2 sho d 2 sho T Is m traum		19a. Informant's Name/Relationship (Type Jeffrey Teaque/so	n	6666	Brookmon	nd Number or Rura t Terrace	l Route Number	r, City or Town, State, Nashville,	
Baltimore, I permit. Pages 1 an Department of Healimportant: if item 2 any injury or other		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	antoval non State	Chesapea	osition (Name of matory or other place ake Cremat	ory 01-1		20c. Location - City of Beltsvill	
Departition of important in the importan	once		iam-			ral & Cre <u>Av Silver</u>		Service MD 20910	7
Physicia /Medica		23a. Part1. Enter the disease, or complications, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)	cations that caused the de e cause on each line. Cerebrovaso	cular Ac		I, such as cardiac of	r respiratory arr	est,	Approximate Interval Between Onset and Death Years
Examine	je je	Sequentially fist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Atrial Fib	rillatio	on				Years
68760, tificate be executed g physicien and as the burial-translt	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):					
I Records, P.O. Box 68/60, The law requires that the death certificate be executed at has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med		3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	olivery Day Year
cords, P. w requires that been signed b should be deta	هَ ا	Partii. Other significant conditions con	tributing to death but not	resulting in the u	inderlying cause give	n in Part I.		bacco use contribute t es 2 □ No 3 □ P	o the cause of death?
	Completed						24a. Was a autops perform	sy prior to med? death?	utopsy findings available completion of cause of s
Of Vital Re Physician: The this certificate ha	To Be	examiner?	ospital: 1 Inpatient 2	P ☐ ER/Outpatie	nt 3□ DOA Othe	26. Place of Death		nel ence 6 □Other (Spe	acifu)
O = = =	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time o	f 28c. Injury Work			ow injury occurred	suny)
Division the Hospital or Attending hin 24 hours after death. the Funeral Director: After mpletely filled in by the funer			28e. Place of Injury - A building, etc. (Spe	ecify)		ļ.	City or Tow		
Div To the Hospital or within 24 hours afte To the Funeral Dir.	Medicai	29a. Certifier 1 Certifying Physics (Check only 2 Medical Examinate)	sician: To the best of my ner: On the basis of exame and manner stated.	knowledge, deat ination and/or in	th occurred at the tim ivestigation, in my op	e, date and place, a inion, death occurre	and due to the c ed at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
To the To the complex	Ž	1 Korka	DW)	tom 22a) (Type	29c. License D357		2	29d. Date signed <i>(M</i> on 01-16-200	
5	State	- · · · · · · · · · · · · · · · · · · ·	0 W. Edmons	ton Dr.		MD 20852	2		
	istrar	JAN 2 0 2006	Alberta de	1 for	Les .	yo. 5	31 2 30 E	CF (#5)	- 10

DHMH 17 Rev 1/2001

Amend Item: 26 per Phys. G-851 1/20/06 reb State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** January 11, 2006 9:05 P M William C. Geist, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel 1684 Nickerson Way Arnold If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**♥**M 2□F Yrs. MD Director 214-12-2550 82 May 6, Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28e-f show the Medical Exercise must be notified at 1 Yes 2 No Directo Queen Annes Chester MD10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? USA 21619 1745 Harbor Drive filed within 72 hours after death Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: δ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Real Estate Appraiser permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked othe any injury or other treumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mildred Wagoner Edgar L. Geist 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1684 Nickerson Way, Arnold, MD 21012 William C. Geist, Jr. Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 1/15/06 Carroll Cremation Hampstead, MD 21. Sigratus - Francisco Licensee 22. Name and Address of Facility 11824 Reisterstown Road Reisterstown, MD 21136 Eline Funeral Home 23a. Part1. Enter the disease, or compile the 1 hat caused the stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Melgroma **Physician** Metrotate 795 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy ned by the atter Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 2 No 1 Yes 1 Yes Be 25. Was case referred to medical filled in by the funeral director 26. Place of Death (Check only one) Hospital: 1 \square Inpatient 2 \square ER/Outpatient 3 \square DOA Other: 4 \square Nursing Home 5 Hospidence 6 \square Other (Specify) Residence Son's 1 🗌 Yes Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After To the Hospitel or Attending 1 Natural 5 Pending М 1 Yes 2 No € ☐ Accident investigation after death 3 🔲 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Paragraphysicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 038409 13/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rel 井イル (Melle. Shartma 12113 FEILY William 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 2

0 2006

		•	State of Maryland / Department Certificate Certificate	nt of Health and Me te of Death		2000	1073
			Registrar 1. Decedent's Name (First, Middle, Last)		. Date of Death	g. No.	3. Time of Death
	Physici		Theodore W. Henciak	1	Month	Day Year	12:45 PM
	/Medic Examin			Town, or Location of Death	ANVATY	4c. County of Death	
1	Examili	er		ndalk		Baltimore	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under		Date of Birth (Month, Day,	1	ace (State or Foreign
	Director		216 03 9507 17 M 20 F 86 Yrs. Months		(Month, Day,	1919 Faltim	ore Maryland
1	D .		Usual Residence of Decedent				
	rylar	_	10a. State 10b. County 10c. City, Town or Location	n 1		10	d. Inside City Limits
	e Ma	cto	Maryland Baltimore Sparrows	Point			1 ☐ Yes 2 M No
	ith th or 28	Oire		Code	10	g. Citizen of What Count	ry?
	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Ither than "natural", or items 23a or 28a-f show int, the Medical Executer interties notified.	Funeral Director	2472 Lodge Farm Koad	21219		USA	
	r deg	ne	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Forces? 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was Decedent Ever	dent of Hispanic Origin? (Specificity Cuban, Mexican, Puerto Richard	fy Yes or No- can, etc.)	14. Race - America Black, White, e	
36	s afte	by Fi	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes	2 No Specify:		Specify: Like	1
Ô	hours lural',		3 Widowed 4 Divorced Year or Dates:	10			
5	n 72 "nai	lete	15. Decedent's Education (Specify only highest grade completed) (Give kind of we life DO NOT:	ial Occupation ork done during most of working işe retired)	, 1	6b. Kind of Business/Ind	ustry
12	withi ene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		i	Glen L. M	artin
2	filed Hygi thar	ပို	17. Father's Name (First, Middle, Last)	18. Mother's Name (I			
Maryland 21215-0036	d be ental ced o	To Be	William Henciak	Mary	olei		
2	should nd Mer marke	F		s (Street and Number or Rural F			Code)
2	and 2 seath ar n 27 is			1 6		Point, MD.	21219
<u>ة</u>	Hea Hea tam otha	Ì	20a. Method of Disposition 20b. Place of Disposition (Na	me of Dat		Oc. Location - City or Tov	vn, State
JO L	ages ant of It: If I		1 Burial 2 Cremation 3 Removal from State 1 Department (Specify) 1 Department (Specify)	751148		Baltimore,	Maryland
Baltimore.	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. If liam 27 is marked other than "natural, important: if Itam 27 is marked other than "natural, any injury or other traumatic event, the Medical Eventone.			nd Address of Facility	2004		
Ba	permit. Departr Imports any inju		[Connell	y Frneral Hom	-	omdalk, g.V.	
	·		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mod shock, or heart failure. List only one cause on each line.	de of dving, such as cardiac or r	espiratory arres		1222 Approximate
	D		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	TENY XII	~ ~ ^-		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	IERT DU	SEA	75	Oyears
	Examiner		Due to (or as a consequence of):	HYDED	TEI	USIONE	2) YEARC
	4	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	CITTE	-16-	00010142	/CHN
V	uted Insit	in in	Cause. Enter Underlying Cause (Disease or injury				,
_	be executed sician and burial-transit	Examiner	that initiated events c				
8760.	cate be executed physician and the burial-transit	dical					
.89		au r	V.				
Box	eath certif attending for use a	Z N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliver	v
m	death e atte	cla	in the past 12 months? 1 Ves 2 No. 1 Live birth 2 Fetal death 3 Ectopic pi				Day Year
P.0	It the de by the a	Physician/M	9 Unknown				
	2 P 9	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying of	ause given in Part I.	23e. Did toba	co use contribute to the	cause of death?
rd	quire an sig uld b		CHRCINOMA OF LUNG) .	1 Yes	s 2 □ No 3 □ Proba	bly 4 Unknown
of Vital Records,	aw requ s been 2 shoul	Completed	PERIPHERALVASCULAR N	ISEARE	24a. Was an		sy findings available
Re	stcian: The law certificate has b irector, page 2 s	ШО			autopsy	ed? death?	pletion of cause of
ta	an: tiffica tor, p	a	25. Was case referred to medical	26. Place of Beath (C			2□ No
>	Physician: this certifica ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DC	Other A		nce 6 Other (Specify)	
0	g Ph er th eral		27. Manner of Death 28a. Date of Injury 28b. Time of 2			v injury occurred	
Division	Attanding I ir death. actor: Alter by the funer	atlo	1 Natural 5 Pending (Month, Day Year) Injury 2 □ Accident investigation M	1 ☐ Yes 2 ☐ No			
\ <u>\ </u>	Atta er de acto by th	iffe	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)	y, office 28f	Location (Stre	eet and Number or Rural	Route Number,
	s afte	Certification:	building, etc. (Specify)		City of Town,	State/	
	To tha Hospital or Attandi within 24 hours after death To tha Eunaral Diractor: A completely filled in by the f	ca	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation	at the time, date and place, and	due to the cau	use(s) and manner as sta	ted.
	ha H in 24 ha F plete	Medical	one) and manner stated.	, in my opinion, death occurred	at the time, dat	te and place, and due to t	the cause(s)
	To tha within 2 To tha complet	Σ	29b. Signature and Ititle of certifier 29c	License number	290	d. Date signed (Month, D	ay, Year)
			M.D	77 (100	TH	NV 4K7 19	2006
	Ih		30. Name and address of person who completed daute of death (Item 284) (Topo, Print)	46-ARIT	CHIE	Huly,	
_	lb		BALTIMO	ORE, MAR	TLAN	10 2 122	-5
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		{		
	Registr	ar	LAND A DAGE A A AMERICA				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 1:50 PM Houston >n ces 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CO>3+>1 Hospice Salisbun 1100M100 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Min. Months Hours 1 ☐ M 2 🔀 F 87 242-16-1203 Director 03-15-1918 North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28e-f ehow if Health and Mental Hygiene. Item 27 is marked other than "naturel", or Iteme 23a or 28e-1 shov other traumatic event, the Mudical Expropries must be notified at ¥∰Yes 2 □ No Director Wicomico Mardela Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 23792 Ocean Gateway 21837 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race · American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√CkNo ð lf Yes, Give Year or Dates: Specify: White 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4+ Economist Goverment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Cleveland Wells Bradshaw Ellen Gertrude Bradshaw 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23792 Ocean Gateway Mardela Springs MD 21837 John Cronan/POA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages I Department of H Important: If Ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Uniform Services of the Health Sciences 22. Name and Address of Facility 4 Donation 5 ☐ Other (Specify) 01-19-2006 Bethesda MD 21. Signature of Funeral Service Licensee Rapp Funeral & Cremation Services Me1358 933 Gist Av Silver Spring MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Geath Immediate Cause (Final disease or condition Metest **Physician** Colon 5 MAGNETA resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknows been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 No 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 patient 2 No 1 🗆 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident 5 Pending investigation M 1 TYes 2 No completely filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ALL Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of derth (Item 23a) (Type, Print) 32. Registrar's Stonature State Registrar

			For State Registrar	State of	of Marylar	nd / Depa		of H	ealth a			jiene	006	010	75
			Hegistrar Decedent's Name (First, Middle, Landson Lan	est)		007	incate	OIL	Jean		2. Date of Dea	eg. No.		3. Time of	Death
	Physicia /Medic		Evelyn	Harri							January	Day 14	2006	3:15	Ам
	Examin	er	4a. Facility Name (If not institution, gi		ımber)		,-		Location of				ounty of Death		
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	Funeral Director		047-07-5225	Sex 1 □ M 2 □ X F	7. Age (In yrs.	93 Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day NOV. O	Year) 191	9. Birth	place (State or intry) CT	r Foreign
	and w	1	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside Cit	v Limits
	e Maryler-ferfeho	ctor	Maryland Anne A	rundel				Pa	saden	a				1 🗀 Yes	
	with the	Dire	10e. Street and Number 7873 Kings Arm	Court			10f. Zip		21122		1	0g. Citize	on of What Cou	ntr y ?	
	ns 23	era	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13. \	Was Deced				cify Yes or No- Rican, etc.)	14	I. Race - Ameri	can Indian.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed For 1 ☐ Yes If Yes, Go Year or I	2 X No ive		fYes,spec 1 □ Yes 2		Specify:	Puerto I	Rican, etc.)	1	Black, White, ipecify: W	etc. nite	
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Baltimore,	nit. Faritme ortan injur		21. Signature of Funeral Service Lice	1 0	1/10		. Name and	-		R- Chelle					
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Division	death ctor: y the	licat	2 ☐ Accident investigate 3 ☐ Suicide 6 ☐ Could not l	De Joe Bloom	e of Injury - At h	ome farm str	M eet factory		65 Z [] N	-	8f. Location (St.	reet and	Number or Run	al Boute Numb	ogr
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	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	edicai C	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	miner : On the b	pasis of examina	owledge, death	occurred a	it the time	e, date and inion, death	place, a	nd due to the ca	ause(s) a ate and p	nd manner as s lace, and due t	tated. the cause(s)	
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and man	iner stated.			License					signed (Month,		
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	10		30. Name and address of person who	90mpleted cau	se of death (Iten	n 28a) (Type,	Print)	11	1	11	asvil	11		- 000	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 4a. Facility Name (If not institution, give street and number) **Physician** 2006 Jan. 8:05am M /Medical 4c. County of Deeth 4b City Town or Location of Death Examiner Harkord 800 Chesapeake Drive Havre de Grace If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 2154003024 1 M 8 F Ohio Yrs. 12/05/1915 90 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location rai", or itams 23a or 28a-f ahow Examiner must be notified at 1 X Yes 2 No Directo Havre de Grace MD Harkord 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21078 USA 800 Chesapeake Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: Peges 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 ☑ Widowed 4 ☐ Divorced White. "natural" I Hygiene. other than *natura ont, the Mudical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teller 10th Bank Is marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or other traumatic avent once. 17. Father's Name (First, Middle, Last) Be Caroline McMann Biddle William Webster Lilley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 800 Chesapeake Dr., Havre de Grace, MD 21078 Marcia Boule- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 01/16/06 Haure de Grace. MD Rock Run Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Mitterell-Smithill Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Oyenrs Dement /Medical Due to (or as a consequence of): Breast **Examiner** 6 hears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed 3month 3.1 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1 Yes 2 PNo or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Certification: To Be Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No-28a. Date of Injury (Month, Day Year) 28c. Injury at Work? the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funarel Director: All completely filled in by the fu 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

21215-0036

Baltimore, Maryland

Box 68760.

Registrar

00036715

2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

520 Upper Chesapeake Dr., Suite 211, Bel Air, MD Sheriff Osman

31. Date filed (Month, Day, Year) 32. Registrar's Signature

ORIGINAL

			For State	State of Marylan	d / Depa	artment o	of Health an			9	01077
	æ		Registrar		Cer	uncate	of Death	2 Date	Reg. I	No.	
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Denise Faith He	orner				Mon		9 2006	
	Examin		4a. Facility Name (If not institution, give s			arter.	wn, or Location of E	eath		4c. County of Dea	
		1	Franklin Square				edale	Hrs. Co.		Baltin	
	Funeral		5. Social Security Number 6. Sex 212-70-5583	7. Age (In yrs. 50		If Under 1 \ Months D			of Birth oth, Day, Yea		rthplace (State or Foreign country)
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	or 28	Director	10e. Street and Number			10f. Zip Co	ode		10g. (Citizen of What C	ountry?
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36	s afte , or if	by Fu	1 Never Married 2 Married	1 ☐ Yes 2X No If Yes, Give Year or Dates:		I □ Yes 2√2				Specify: Wh	
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Denise Maryland	d 2 should be filed within 72 hour th and Mental Hygiene. ?7 is marked other then "neturel traumatic event, the Madical Ex	-	19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mailin	g Address (S	Street and Number of				Zip Code)
	s 1 and 2 should f Health and Mer frem 27 is marke other traumatic		Monica Goza - Sis	ter	5946 (Queens	ton Stree	t, Spr	ingfie	ld, Virg	jinia 22152
saltimore,	permit. Pages 1 and 2 Department of Health a Important: if item 27 is eny injury or other trai		20a. Method of Disposition	1 0	lace of Disposemetery, crem	sition (Name	of	Date	- 100	Location - City or	
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I			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death	h. Do not ente	er the mode o	of dying, such as ca	rdiac or respira	itory arrest,	_	Approximate Interval Between
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B	death atte	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregr Other (s <i>peci</i>				Month	Day Year
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Division of Vital Records, P.O. Box 68	Attending Physician: The law requires that the death certifica r death. ector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as th	Completed by Physician/Med	Part II. Dther significent conditions con	tributing to death but not resi	ulting in the ur	nderlying caus	se given in Part I.	23e	. Did tobacc	o use contribute t	o the cause of death?
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Sio	endi eath. or: A he fu	atle	2 Accident investigation			М	1 ☐ Yes 2 ☐ No				
≅	ier direct	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre v)	eet, factory, o	ffice	28f. Loca City	tion (Street or Town, Sta	and Number or R ite)	lural Route Number,
	Hospital or ta hours afte Funeral Dir tely filled in I										
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	sicien: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at t restigation, in	the time, date and p my opinion, death o	lace, and due occurred at the	to the cause time, date a	(s) and manner a ind place, and du	s stated. e to the cause(s)
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	X		30. Name and address of person who co	moleted cause of death //tem	1 23a) (Type 1		E 5 0000			11/0	Ø
	10		DR Cassandra Wil	liams 4000 Fre	anklin S	guare I	Drive Bo	Utimos	e M	D 2123	57
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	29					
-	Regist	rar	JAN 2 0 2006	Janes Jan	See See See	-					And the second

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Physician 2006 JAN 8:00AM 9 /Medical 4c. County of Deat Examiner If Under 1 Year ce (State or Foreign 7. Age (n yrge last birthday) **Funeral** 112M 2□ F Months Days Yrs. Director or Location 10d. Inside City Limits if itan 27 is marked other than "natural", or items 23s or 28s-f show or other traumstic event, the Medical Examiner must be notified at 1₽ Yes 2□ No **Funeral Director** 10f. Zip Code Was Decedent Ever in U,S. Armod Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: nt of Hispanic Origin? (Specify Yes or No-y Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1□ Yes 2 No Baltimore, Maryland 21215-0020 Specify Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOTruse retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Busines g∯ry (0-12) ather's Name (First, Middle Pages 1 and 2 should be nent of Health and Mantal Date 1 Burial 2 ☐ Cremation 5 Other (Specify) 21. Signature of Funeral Service Licen ter the disease, or complications that caused the death. Do not enter heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Cardiac 15 MIHARS Examiner Medical Certification: To Be Completed by Physician/Medical Examiner heart diseuse heroscleroka 1 yeev or Attending Physician: The law raquiras that the death certificate be axecuted eeral Director: After this cartificate has been signed by the attending physician and filled in by the funeral director, page 2 should be datached for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown encephalopathy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? pertension mellitus Dichetes TUYUS 20 NU 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1-18-2006 D 30494 OR DESAIM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles street Baltimore MO 21230

DHMH 16 Rev 6/95

State Registrar

DESAIMO

31. Date filed (Month, Day, Year)

M

601 32 Registrar's Signature

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South

			1 - For State Registrar		partment of Health and Nertificate of Death		ene 006	01079
			Decedent's Name (First, Middle, Last)			2. Date of Death Month		3. Time of Death
	Physici /Medic		Almeda Mae	Johnson		January	17° 2006°	1:25AM M
1.	Examin	er	4a. Facility Name (If not institution, give street and n	umber)	4b. City, Town, or Location of Death		4c. County of Death	
	. 3	£ 2	Southern Maryland Hos 5. Social Security Number 6. Sex	pital 7. Age (In yrs. last birthday	Clinton. If Under 1 Year If Under 24 Hrs.	B. Data of Bigh	Prince Geo	
	Funeral Director		188-20-8994 1□M 2□XF	83 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, July 31	, 1922 PA	place (State or Foreign ntry)
	4		Usual Residence of Decedent				, , , , , , , , , , , , , , , , , , , ,	
	irylan show		10a. State 10b. County	10c. City, Town or L			1	10d. Inside City Limits
	Ba-f	Director	Maryland Prince George'	s F	ort Washington			1 ☐ Yes 2 ☑ No
	th with the 23a or 2 ast be n.	ai Dire	10e. Street and Number 3309 Marston Drive		10f. Zip Code 20744	10	Og. Citizen of What Cour U.S.A.	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or iteme 23e or 28e-f show ship injury or other treumatic event, the Medical Examinar must be neitlied at ance.	by Funeral	V Armed F	i 2 ₾ No Bive	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
Baltimore, Maryland 21215-0036	within 72 ho ane. then "netur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College	(Giv (1-4or 5+)	edent's Usual Occupation le kind of work done during most of work DO NOT use retired) Omemaker	ing 1	6b. Kind of Business/In	•
d 2	Hygie ther ther	ပိ	17. Father's Name (First, Middle, Last)	11		e (First, Middle, M	Hom	ie
an	id be ental ked o	To Be	Elmer S. Flenner		Myrtle	Cromer		
ary	should ind Men in marke umatic	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Street and Number or Rur	al Route Number,	City or Town, State, Zig	Code)
Σ	s 1 and 2. of Health ar item 27 is		Robert M. Johnson (Husb	and) 3309	Marston Drive Ft.	Washingt	con, Maryla	nd 20744
ore	of He of He fiterr		20a. Method of Disposition 1		ematory or other place) Jan .	Date 20,	Oc. Location - City or To	own, State
Ĕ	Pages ment of I ant: If its ury or o		4 □ Donation 5 □ Other (Specify)	Broad T	op City Cem. 200		Broad Top C	
Ball	permit. Depertr Imports eny inju		21. Signature of Funeral Service Licensee Micula D. Subby n		22. Name and Address of Facility ${ m L}_{ m 6}$			
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not en	1			Approximate Interval Between
0	Physician		Immediate Cause (Final disease or condition	Meta	static Color	Con	en	Onset and Death
4	/Medical Examiner		resulting in death)	o (or as a consequence of):				
		_	Sequentially fist conditions, b.	o (or as a consequence of):				
T	nsit	Examiner	cause. Enter Undertying Cause (Disease or injury	7 (or as a consequence or).				
V	execu n end ial-tra	Exar	that initiated events c.	o (or as a consequence of):				
8760,	cate be executed physicien end the burial-transit	dicai	d.					
9	tificating physics the sth							
.O. Box	The law requires that the death certificate be executed ate has been signed by the ettending physicien end page 2 should be detached for use es the burial-transit	by Physician/Me	in the past 12 months?	gnant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of defive Month	ery Day Year
<u>α</u>	s that ned b a deta	y P	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the	he cause of death?
rds	w require been sig should b	edb				1 ☐ Yes	s 2□No 3□Prob	pably 4 JUnknown
Division of Vital Records,	ysicien: The law requ is certificate hes been director, page 2 should	Completed				24a. Was an autopsy perform	prior to co- death?	opsy findings available impletion of cause of
ta		a	25. Was case referred to medical	- /	26 Place of Deat	1 ☐ Yes 2 h /Check only one	**	2□ No
<u>></u>	ysici lis cer direc	ToB	examiner? 1 Yes 2 Hospital:	Inpatient 2 DevOutpatie	Other		nce 6 Other (Specif	⁽ ن)
0 0	Attending Physicien: r death. ector: After this certific by the funeral director,		27. Manner of Death 28a. Date 1 □ Netural 5 □ Pending (Mo	e of Injury 28b. Time onth, Day Year) Injury		28d. Describe how	v injury occurred	
Sio	ttendii death. ctor: A / the fu	cati	2 Accident Investigation	<u> </u>	M 1 ☐ Yes 2 ☐ No			
Σ	l or Atten after deatl Director: I in by the	Certification:	4 Homicide determined 28e. Place	ce of fnjury - At home, farm, s Iding, etc. <i>(Specify)</i>	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
	pitel ours a erel (29a. Certifier 1 Dertifying Physician: To the	he heat of my knowledge, de-	ath occurred at the time, date and place,			
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical	(Check only 2) Medical Examiner: On the	basis of examination and/or inner stated.	investigation, in my opinion, death occur	red at the time, da	te and place, and due to	tated. o the cause(s)
	To the vithing To the company of the	Σ	29b. Signature and title of certifier		29c. License number		d. Date signed (Month,	Day, Year)
	4		12/		50454	7	5anango	17706
	4		30. Name and address of person who completed ca		SOUJY Print) Silvesspeins			
0	70.072 - 6-00.		(0010.50.30.1.00	Registrar's Signature	& July Jegins	MD 3	20902	
4	Sta Registi		19 N 9 A 2006	Daniel M. A.	32460			
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		1 For State	of Maryland / Dep			ental Hygier	19 006	01080
		Registrar 1. Decedent's Name (First, Middle, Last)	Ce	rtificate of Dea		Reg. I	No.	3. Time of Death
Physic /Med		SANDRA	Johns	on			18 2006	2158 M
Exam		4a. Facility Name (If not institution, give street and r	r ()	4b. City, Town, or Locat	tion of Death	115	4c. County of Dea	
Funera		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday		Tour der 24 Hrs. 8	3. Date of Birth	9. Birt	thplace (State or Foreign
Directo		220-52-7007 10M 2XF	57 Yrs.	Months Days Hou	ırs Min.	Month Day, Ye.	8 00	ountry)
/and		Usual Residence of Decedent 10a. State 10b. County	10c City, Town or L	ocation				10d. Inside City Limits
e Man	ctor	MD Baltimor	e Kand	allstown	\			1 □ Yes 2 🐪 Vo
ore, Maryland 21215-0036 s.1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "naturel; or items 23s or 28s-1 show other traumatic event, the Medical Examinational Examinational and items 23s.	Funeral Director	8822 Allenswood A	200d	10f. Zip Code 21133	ζ	10g.	Citizen of What Co	ountry?
r death	nera	11. Marital Status 12. Was De	ocedent Ever in U.S. 13. Forces?	Was Decedent of Hispanic If Yes, specify Cuban, Mex		ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit	erican Indian, e. etc.
-0036 hours after turel; or its	by Fi	1 Never Married Marned 1 Yes, 6 3 Widowed 4 Divorced Year or	Sive No	1 ☐ Yes 2 No Spe			Specify:	lack
5-0036 72 hours af naturel; or dical Exemple	eted	15. Decedent's Education (Specify only highest grade complete)	d) 16a. Dece	edent's Usual Occupation e kind of work done during t DO NOT use retired)	most of working	16b	Kind of Business	/Industry
d 2121 filed within Hygiene. other then "	Completed	Elementary/Secondary (0-12) College	(1-4or 5+)	/ 1 / /	vider	C	hild (ave.
be filed tal Hygi of other	Be C	17. Father's Name (First Middle, Last)	7			First, Middle, Maid		
Maryland d 2 should be file the and Mental Hy 7 is marked oth traumatic event	2	James Kichard So 19a, Informant's Name/Relationship (Type, Print)		ling Address (Street and Nu	ertho	DANASHA TURA I	rison y or Town, State,	Zin Codo)
Te, Mar 1 and 2 sho Health and 10m 27 is m		Allan S. Johnson, Sr	/. / 1 1	aAllenswood	1 () [Randa	Ustown	MD 21133
0 2 = 5		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from	m State 20b. Place of Disp	osition (Name of anatory or other place)	Da	. 7	Location - City or	Town, State
Baltimo permit. Pag Department Important: I eny injury o	Į.	4 □ Donation 5 □ Other (Specify) 21. Sign ture of Hurreral Service Ligan ee	Druid K	Cide and Apdresson F	1-25	-06 M	Kesui 114	e, one
Bal permi Depa impo		Naughn C. Steese	8	728 2 bert	PJ.	Pandall	Stown, 1	NS 2/133
JUST B		23a. Part1. Ental the disease, or complications that shock, or heart failure. List only one cause or Immediate Cause (Final	t caused the death. Do not en n each line.					Approximate Interval Between Onset and Death
Physician /Medica	_	disease or condition resulting in death)	POSCIERO (C. 10)	COPONARY 1	Unterry	Diser	rse	
Examine		Sequentially list conditions, b	optic Valu	ve Diseas	e			
The Lifed	Examiner	cause. Enter Underlying Cause (Disease or injury	o (or as a consequence of):					
58760, cicate be executed physician and sthe burial-transit		that initiated events c	o (or as a consequence of):					
68760 ifficate be e g physician as the buria	dlca	d						
. Box 68760, death certificate be exe e attending physician and for use as the burial-ti	an/Me	230. Was decedent pregnant	outcome of pregnancy	□Ectopic pregnancy			23d. Date of de	*
P.O. Bratthe deat deby the att	Physician/Medical		gnant at time of death 5	Other (specify)			Month	Day Year
	by Ph	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given in P	Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ecords, law requires as been sign 2 should be						1 🗆 Yes	2 No 3 P	obabły 4 Unknown
~ □ □	Completed					24a. Was an autopsy performed	24b. Were au prior to death?	utopsy findings available completion of cause of
Vital F vicion: Th certificate rector, pag	0	25. Was case referred to medical		26. F	Place of Death /	1 Yes 2	No 1 ☐ Yes	2 No
<u>~</u> ≥	To B		Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4		e 5 ☐ Residence	6 □Other (Spe	cify)
Vision C Attending P octor: After by the funera	tlon:	27. Manner of Death 28a. Date of Matural 2 Accident investigation	te of Injury onth, Day Year) 28b. Time Injury	of 28c, Injury at Work? M 1 Tyes		d. Describe how in	ijury occurred	
Division of all or Attending Phy after death. I Director: After this d in by the funeral d	Certification:	3 Suicide 6 Could not be	ce of Injury - At home, farm, s Iding, etc. (Specify)		-	If Location (Street City or Town, St	and Number or Re	ural Route Number.
Hospital or thours afte Funeral Dir tely filled in		29a. Certifier 1 Certifying Physician: To t		th converse at the time det	he and place an			
Division or To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	(Check only 2 Medical/Examiner: On the	basis of examination and/or i anner stated.	nvestigation, in my opinion,	death occurred	d at the time, date	and place, and due	s stated. e to the cause(s)
To the within 2 To the complet	Σ	29b. Signature and title of certifler	\wedge	29c. License numb			Date signed (Mont	. 16
1		30 Name and address of person who completed ca	use of death (Item 23a) (Type	D 00 5	5645	0 3	wey	19 2006
15		Rodney Biglow, M.	D. 5401 OH	Court Road	d Ran	dalls four	CM,	21133
2 × 3 × 5 × 6	tate	31. Date filed (Mehth, Day, Year) 32 JAN 2 0 2006	Redistrar's Signature	1 .	•		•	

			State of Maryland / Department	artment of Health and M rtificate of Death	lental Hygiei Reg.	
ı	Physicia		Decedent's Name (First, Middle, Last) Raymond Wilson Johnson Sr.		2. Date of Death Month January	3. Time of Death 2:30 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Hart Heritage Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Street If Under 1 Year If Under 24 Hrs.	O. Data of Birth	Harford
	Funeral Director		N 2□E Vo	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	
			215-12-3273 82 Wsual Residence of Decedent		Apr. 18,	1923 Maryland
	nylan how		10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits
	Ba-1 s	cto	Maryland Harford Bel Ai			1 ∑XYes 2 ☐ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any figury or other traumatic svant, ite Medical Evarities must be notified at anone.	al Director	10e. Street and Number 20 Hillendale Road	10f. Zip Code 21014	10g.	Citizen of What Country? USA
	ems deal	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
9	or It	by F.	1 ☐ Never Married 2 ☐ Married 1 ☐ Ses 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: White
215-0036	hour			dent's Usual Occupation	166	. Kind of Business/Industry
212	n "ne	Completed	(Specify only highest grade completed) (Give	kind of work done during most of worki DO NOT use retired)	ing	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
7 7	d with giene	mo:	12 Prin	iter	Pı	cint Media
2	al Hy d other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	First, Middle, Maid	
Maryland	ould b Ment warked	To		Mary	Frances	Wilson
<u>a</u>	12 sh h and 7 is m traum		1.1.1	ng Address (Street and Number or Rura		
a)	1 and Healt em 2		20a Method of Disposition 20b. Place of Dispo	Conowingo Road, E		Location - City or Town, State
Baltimore,	Pages ment of lant: If It		cemetery, cre	matory or other place)		cest Hill, Maryland
Rai	permit Depart Import any In		ttil and	2. Name and Address of Facility McC 317 Cokesbury Road	Comas Fund d, Abingdo	eral Home, P.A. on, Maryland 21009
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac o	or respiratory arrest,	
	Pnysician :	į U	Immediate Cause (Final disease or condition	e Heart Pail	un	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	,		
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	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events c.			
60,	be exectan a	EX	Due to (or as a consequence of):			
58760,	physi physi the b	dlcal	d			
×	certifi nding ise as		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Box	death a atter	Physician/M	1 Live birth 2 Fetal death 3 in the past 12 months? 1 Ves 2 MNo 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month Day Year
д О	t the c by the achec	hysi	9 ☐ Unknown			
ຜົ	ss thai	by P	Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
ğ	equire een sii		PANLUNIONS		1 🗌 Yes	2 No 3 Probably 4 Anknown
Division of Vital Records,	he law r e has be age 2 sh	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
ta	an: T	Be C	25. Was case referred to medical	26. Place of Death	1 ☐ Yes 2Ø	
	nystci nis ce direc	ToE	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	nt 3□ DOA Other: 4□ Nursing Ho	me 5 Residence	ASSISTED B 6 KOther (Specify) Come
0	ng Pl		27. Manner of Death 1. Natural 5 □ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) Injury	Work?	28d. Describe how i	njury occurred
Sio	tandi leath. tor: A the fu	catl	2 Accident investigation	M 1 Yes 2 No		
DIX	after dated Direction by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	freet, factory, office	City or Town, S	t and Number or Rural Route Number, late)
	To the Hospital or Attending Physicien: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea 2 Medical Exeminer: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the caus red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	ro the vithin o the	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	->-0		Idn An Mo	735889	J	1~16,2006
			30. Name and address of person who completed cause of death (Item 23a) (Type ALFMAN SPANUS 613 W-			
	Sta	ate				,
	Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature			

		•	For State Registrar	State of Marylan	-	artment of H		d Mental H	lygiene Reg. No.	HILL	01082
	Physici	an	1. Decedent's Name (First, Middle, Last Merle Davis Kirk)					2. Date of Month Jan.	Death 19	2006	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of De			County of Death	5:00 P M
			3026 Birdview Ros 5. Social Security Number 6. Se		last hirthday)	Westmin		Hrs. 8. Date of		roll	place (State or Foreign
	Funeral Director			x 7. Age (iii y/s. 7	7 Yrs.	Months Days			Day, Year)	Cou	ntry)
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	e-f sh	ctor	MD Carroll	We	estmins	ster					1 ☐ Yes 2 X No
	with the	Director	10e. Street and Number 3026 Birdview Roa	ad	•	10f. Zip Code 21157				zen of What Cou	•
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H	ispanic Origin?	(Specify Yes or		14. Race - Ameri	can Indian,
36	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "neturel", or terms 23a or 28e-f show event, the Modical Eracinar must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2V No If Yes, Give Year or Dates:	1	1 ☐ Yes 2 🌠 No		Jesto Filozof, etc.)		Specify: Whi	
2-00	72 hou neture lical E		15. Decedent's Edu (Specify only highest grad	ucation	16a. Dece	dent's Usual Occupa	ation during most of	workina	16b. Ki	nd of Business/Ir	
Maryland 21215-0036	within lene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Homen	kind of work done of DO NOT use retired	4)		Hor	: home	
nd 2	be filed ital Hygi id other event, I	Be Co	17. Father's Name (First, Middle, Last)		Homen	IGREE		Name (First, Mide	de, Maiden	Sumame)	
yla	2 should be f and Mental F is marked of reumatic eve	To I	Mark Fuston Quese		10h Maili	ng Address (Street		y Ella N			n Code)
	日前に		Patty Barnes	Daughter		Jueller R		minster.		21157	o Code)
Baltimore,	00-	1	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ f		emetery, crei	natory or other place	ce) Ja	Date	20c. Lo	cation - City or T	own, State
Ħ	permit. Pag Department Importent: I any injury o		* 4 □ Donation 5 □ Other (Specify, 21. Signature of Euperal Service and Servi	LIMO	Cemet	e Calvary erv		n. 23,		sburg,	
Ba	permit. Departn Importe any injt		1 Colly	feler		rrier-Ou 212 W. Old	een fun d Liber	eral Hon ty Road	ne & (Winf	remator ield, M	y, 21784
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the deat ne cause on each line.		,	1774		arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseq	Lence of):	-stage	De ne	Ma			one month
	Examiner		Sequentially list conditions,	b							sappar - og
T	t t insit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury	Due to (or as a conseq	uence of):						
V_ 0	be executed sician and burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
68760,	ate the	edical		d							
Вох	eath certific attending p	an/M	23b. was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy	,		2	23d. Date of deliv	- /
O. E	at the dea by the at tached fo	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of d 9□ Unknown	eath 5	Other (specify)			-	MORE	Day Year
S, P	es that igned b be deta	by Pt	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause give	en in Part I.			/	the cause of death?
Records,	w requir been si should										bably 4 Unknown
Rec	The law	Completed						24a. W au pe 1 □ Yes	rformed?	prior to co	opsy findings available ompletion of cause of
of Vital	Physicien: This certificatal director, p	BeC	25. Was case referred to medical examiner?					Death (Check on		10103	2010
	Phys rthis ral di	: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o	f 28c. Injun	y at	g Home 5 Re			fy)
sion	Attending I r death. ector: After by the funer	atlo	1 Accident 5 Pending investigation	(Month, Day Year)	Injury	M 1	k? Yes 2 □ No				
Division		ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, str	eet, factory, office			(Street and Town, State,		al Route Number,
	Hospite 4 hours Funerel ely filled	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exam	rsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, deat ition and/or in	h occurred at the tin vestigation, in my o	ne, date and pl pinion, death o	ace, and due to the	ne cause(s) e, date and	and manner as splace, and due to	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	John Me	1.0	29c. Licens	- /	7117	1	e signed (Month,	
•	^		30. Name and address of person who	ometheted cause of death /liver	n 23a) (Tuno	Print)		43	Jane	uary 20;	2006
_	1		John Abel M	D. 295	Stor	er Are.	Suy	4307	h	But, 1	20e6 10:21157
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 0	2006 Agriculture	ature	Courte)				, .	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene of Co.

		For State Registrar	State of Marylan		ate of Death	Mental Hyglene Reg. No	LUUU UIUUJ
		1. Decedent's Name (First, Middle, Las.)	1/	- 1	2. Date of Death Month Da	3. Time of Death
Physici /Medi	_	MABEL	LULA	KELL	EY	JAN 1	7 2006 1157 M
Examir	ıer	4a. Facility Name (If not institution, give	of BALTIMOR		SALTIMORE, CI		c. County of Death
		SINK HOSPITAL 5. Social Security Number 6. Se		-	ider 1 Year If Under 24 Hrs	8 Date of Birth	9. Birthplace (State or Foreign
Funeral Director			DM 21€F	7 Yrs. Mont	hs Days Hours Min	FEB 21.19	9. Birthplace (State or Foreign Country) MARVLAND
*		Usual Residence of Decedent				7.	
arylan ehow	7	10a. State 10b. County	10c. Cit	y, Town or Location	2 1/2	0= 17 -11	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
he M. 28a-1	ecto	MARYLAND 10e. Street and Number	IA	101	SALTIMO! Zip Code		itizen of What Country?
with	直	21110 61	NED STOR		212	11-	11.54.
death me 23	Funeral Director	11. Marital Status	12. Was Decedent Ever in U	.S. 13. Was D	acedent of Hispanic Origin? (Specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - American Indian,
or Ite	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		s 2 X No Specify:	to Alcan, etc.)	Black, White, etc. Specify: 17
Iled within 72 hours after death with the Maryland Hygiene. Hygiene. Sther then "natural", or Iteme 23a or 28a-f ehow ent, the Madical Examinatoriative incitied at	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:			10.	BLACK
n 72 h	Completed	15. Decedent's Ed (Specify only highest grades)	de completed)	16a. Decedent's (Give kind o	Jsual Occupation fwork done during most of wo IT use retired)	orking 166. P	Kind of Business/Industry
iene.	ошр	Elementary/Secondary (0-12)	College (1-4or 5+)	(ZOOK	PA	RIVATE SCHOOL
e filec other	Bec	17. Father's Name (First, Middle, Last)				me (First, Middle, Maide	
tal y lailu K. i.K. 2 should be filed within and Mental Hygiene. is marked other then sumatic event, the Ms	ToE	SYLVESTER	(JAINE		NCES	WILSON
2 should and Men is marke	1	19a. Informant's Name/Relationship (7		19b. Mailing Add	ress (Street and Number or R	166	BACESC CO
Tand Health Health Health Health		FRANCES GAIN 20a. Method of Disposition		Place of Disposition	N. LONGUE	and the second second	Location - City or Town, State
Pages nent of the		1 Burial 2 Cremation 3	Removal from State	cemetery, crematory	or other place)	4 0	
그 문문을	1	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen					INGS MILLS MD.
permit. Depart Import any inj	Ш	Dietuch	N. Wille	mo 31	SEPHH HIB	DAVE. BA	-UNERAL HOME LTO. MD. 21217
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the deat				Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		Georg	CANCER		Onset and Death
/Medical		resulting in death)	Due to (or as a consec	quence of):	Charles		
Examiner	_	Sequentially list conditions.	b. Due to (or as a consec	Maria (Sept.			
V pe d ist	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quenca or).			
al-tran	xar	that initiated events resulting in death) Last	c. Due to (or as a consequence)	quence of):			
ificate be executed g physicien and as the burial-transit	edical		d				
		IE EEMALE:					
BOX of eath certifications attending for use as	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnative birth 2 ☐ Feta	al death 3 Ectop	ic pregnancy		23d. Date of delivery Month Day Year
the a	/slc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of c 9☐Unknown	death 5 ☐ Othe	r (specify)		•
The law requires that the death cert as has been signed by the attending togge 2 should be detached for use	Completed by Physician/M	Part II. Other significant conditions o	ontributing to death but not res	sulting in the underly	ng cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
w requires to been signs should be	d b	CONGESTIVE HE	ART FAILURE			1 ☐ Yes 2	2. No 3 ☐ Probably 4 ☐Unknown
w req	lete	CARDIOMYOPATH	(1			24a. Was an	24b. Were autopsy findings available prior to completion of cause of
The lar	mo		3			autopsy performed? 1 ☐ Yes 2 ☑ N	death?
VICAL TO ician: The certificate h ector, paga	BeC	25. Was case referred to medical examiner?			26. Place of De	eath (Check only one)	
OI V Physic r this ce ral dire	To	1 ☐ Yes 2 ◯ No				Home 5 Residence	
ing P	on:	27. Manuer of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how inju	ury occurred
DIVISION Tor Attending after death. Director: After	Icat	2 Accident investigation 3 Suicide 6 Could not be			1 Yes 2 No	28f. Location (Street a	and Number or Rural Route Number,
after Direction by	Certification:	4 Homicide determined	building, etc. (Speci	fy)	otory, onto	City or Town, Sta	
To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use			ysician: To the best of my kn				
n 24 h n 24 h he Fu	edical	(Check only 2 Medical Examone)	and manner stated.	ation and/or investig	ation, in my opinion, death occ		nd place, and due to the cause(s)
To the comp	ž	29b. Signature and title of certifier			29c. License number		ate signed (Month, Day, Year)
		1 Common	ND		RES-000	'AL	NULRY 17, 2006
				m 23a) (Tuna Brint)			
		30. Name and wdre's ol person who			OUTL OF C	AT IS TO THE	
1	ato	30. Name and a dre s of person who ALYSSA LETTICH 31. Date filed (Month, Day, Year)			PITAL OF E	BALTIMORE	
Si Regis	ate trar	ALYSSA LETTICH			E TAL OF E	BALTIMORE	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 18, Anna C. Kern 2006 9:55 A January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 8. Date of Birth (Month, Day, Year) Baltimore Perry Hall 9608 Havenjarm Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Mary Land 1 □ M 2 💢 F 102 Director 215-60-1698 Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location r then "natural", or Items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 1 No Director Perry Hall Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number u.s. 21128 9608 Havenharm Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💆 No 3 X Widowed 4 □ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "nat any injury or other treumatic event, the Madica 2008. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 6th Grade Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Anne Loretta Clarke Joseph T. Curley 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9608 Havenfarm Road, Perry Hall, Maryland 21128 Pat Andrykes (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Holy Cross Cemetery 01/20/2006 Glen Burnie, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Co 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Road, Baltimore, Maryland 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Hypertens, ve Arterios cleratic Cardio vascular Disense Dubib (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Be Completed by Physician/Medical for use as the been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. well. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has 995 L CHACI B12 NOW 2 X No 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) npletely filled in by 4 Homicide within 24 hours a

To the Funerel I

completely filled 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and the q 19 06 026203 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1319 Light St. Baltimore Vallecillo MO 31. Date filed (Month, Day, Year) 32. egistrar's Signature State JAN 2 0 Registrar 2006

			State of Maryland / Department of Health and Me 1- State Registrar Certificate of Death	ental Hygiei Reg.	Z 111116	01085
er.	Dharaini	4	Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year	3. Time of Death
	Physici /Medi			January 1	7, 2006	3:14 A M
1	Examir	ıer	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
- N	Funeral	95	Civista Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	B. Date of Birth	Charl 9. Birthp	lace (State or Foreign
	Director		578-28-1775 1 M 2 F 79 Yrs. Months Days Hours Min.	B. Date of Birth (Month, Day, Ye AUS . 24	1926 Was	Mington IC
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits
	Maryling a	tor	Maryland Charles Waldorf			1 ☐ Yes 2 ☒ No
	n the	irec	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Cour	
	23a c	aiD	11080 Weymouth Ct. Apt. 326 20603		U.S.A	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, Ira Medical Examinar must be notified at once.	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Sive \(\Delta\) Year or Dates: 13. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri I □ Yes, Sive \(\Delta\) 1 □ Yes 2 □ No Specify:	ify Yes or No- ican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
5-0	natu	letec	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of working life. DO NOT use retired)	g 16b	. Kind of Business/In	dustry
12	2 should be filled within and Mental Hygiene. Is marked other than sumstic avant, Ire Ms	Completed	Elementary/Secondary (0-12) 10th College (1-4or 5+) Computer Analyst		NASA	
b	be filed ta! Hygi d other	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name (,	
ylaı	should b ind Ments marked umatic a	To	John James Kendrick Blanche		Robinson	
Maryland	12 sh h and 7 la m traum		19a. Informant's Name/Relationship (Type, Print) Elizabeth L. Kendrick (Wife) 19b. Mailing Address (Street and Number or Rural, 11080 Weymouth Ct. Apt.			
	Health tam 27		Elizabeth L. Kendrick (Wife) 11080 Weymouth Ct. Apt. 20a. Method of Disposition 1A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan.		Location - City or To	
Baltimore,	Pages ment of ant: If It ury or o		1\(\bar{\Delta}\) Burial 2 \(\subseteq\) Cremation 3 \(\subseteq\) Resurrection Cemetery 2006		Clinton, M	aryland
Balt	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee 6633 Old Alexandria		Home, Inc	
			23a. • n1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Respiratory Jalune or te chain	1	Bear	Onset and Death
	/Medical Examiner		Que to (3r as a consequence 4):	5 1 13		
-34	7 - 2	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Borow	Willer-	
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	e death	Physician/M	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
P.0	that the de led by the a detached t		9 Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23a Did tobacc	co use contribute to the	to course of death?
Records,	uires tha signed l	Completed by	Suk Smy Swelvers.	1 Tes		ably 4 Unknown
000	aw require s been sig should b	ojete	HIM	24a. Was an	24b. Were auto	psy findings available
		omo	Alz . Monachia.	autopsy performed	? death?	npletion of cause of
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of Vital	Physician: r this certificated frall director,	T.		e 5 Residence	6 Other (Specific	()
O	fing Afte fune	tion	27. Manner of Death 28a. Date of Injury 28b. Time of Work? 1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident Investigation M M	od. Describe now ii	njury occurred	
Division	Hospital or Attending 4 hours after death. Funeral Director: After tely filled in by the fune	Certification:	3 Suicide 6 Could not be	Bf. Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one) 1	d at the time, date	(5) and manner as s and place, and due to	ateu. the cause(s)
	To the Within 2 To the comple	Me	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month,	Day, Year)
)			DOON + 200 MAS	1/ 80	118/06	9
	B		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	40/-1	an	20139
	Sta Regist		31. Date filed (Month, Day, Year) JAN 2 0 2006	0		7.11
	3		Unit is a second			

Amend item#8, perfH, 331, 1/23/16 IT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year 335 P M Physician Kinzison Kandall Tanualy 16,200 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery Montgomery Hospital Olnew Gieneral If Under 24 Hrs. 8. Date of Birth Hours Min. (Month Day) 03/08/1921 7. Age (In yrs. last birthday) XYrs. If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Days Year 1 M 2 □ F 001-14-3990 Vermont Director Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at Spring Sandy 1 ☐ Yes 2 KNo WD Montgomeru Completed by Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ane # B3 20860 USA 17320 Quaker filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Byes 2 □ No If Yes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No. II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📈 No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) College Professor Education 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Raymond Elizabeth Scatt Kinerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13416 Bartlett St. Rockville, MD 20853 Nancy K. Dwyer Daughter Health Item 27 I 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot once Chesapenke Crematory 1-20-2006 Belts ville MI
22. Name and Address of Facility Rapp Funeral-Cremation SVCS. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Smo1358 933 Grist Ave, Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final Phenemia with empyema Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physicien end for use as the burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. Il yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown sete has been signed to page 2 should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 No 1 Tyes or Attending Physician: tor: After this certific the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide within 24 hours after To the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D39793 Regur 17,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christophar J. Mays, MD 18111 Prince Philip 31. Date liled (Month, Day, Year) 32. Registrar's Signature State 0 2006 Registrar

			1 = Stat Amend Item#18	State of Maryla per FH G852	279/0	partment of I ertificate of	Health and <i>Death</i>	Mental Hyg	giene ()	06	01087
7		Z(A	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath	Year	3. Time of Death
	Physici /Medic		Linda ?	beverly Ke	rsche			January	Day	o Co	5:03 FM
R.	Examin		4a. Facility Name (If not institution, give s				or Location of Dea	,	4c. Count	y of Death	
		2 Mg	Montgomery General	Hospital			lney		Mor	7+301	nery
5,	Funeral		5. Social Security Number 6. Sex	· · ·		Months Days			h /, Yea <i>r)</i>	9. Birthp Cour	place (State or Foreign
ets.	Director		318.02.1107	5 5	7 Yrs.			January 1,		Ma	ryland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or	Location				1	Od. Inside City Limits
	Mary f sho	ō	Maryland Montgor	nery	Bilvec	Spring					1 No 2 No
	the 288	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
	3a or		15035 West	Holm Court		20	906		US		
	d within 72 hours after death with the Maryland Jiene. Ir than "natural", or flema 23a or 28a-f show The Mazical Examinat must be notified at	Funeral		12. Was Decedent Ever in U	J.S. 1	3. Was Decedent of If Yes, specify Cub	Hispanic Origin? (Specify Yes or No-	14. Ra	ce - Americ	
9	or free		1 Never Married 2 Marned	Armed Forces? 1 XYes 2 □ No				rto Rican, etc.)		ck, White,	
8	raff,	d by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates: 1970-	-1977	1 ☐ Yes 2 🛣 No	Specify:		Speci	y: WI	nite
21215-0036	natu dical	Completed	15. Decedent's Edu (Specify only highest grade		(G	cedent's Usual Occu	during most of we	orking	16b. Kind of E	lusiness/in	dustry
21	dithin	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		Registere		0	A	temy	
2	- 12 harden		17. Father's Name (First, Middle, Last)	2		registere	18 Mother's No	me /First Middle			
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Ë	d 2 should be ith and Mental it and Mental it? Is marked o	2	19a. Informant's Name/Relationship (Ty)		19h M:	ailing Address (Stree	and Number or 5	Jural Poute Numbe	r City or Town	State Zin	Codel
Maryland	12 17			/ Mother	1	35 West			-		·
	the He		20a. Method of Disposition	20b.	Place of Dis	sposition (Name of		· · · · · · · · · · · · · · · · · · ·	20c. Location		
20			1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	atomy (rematory or other pla Sifts Registr	Janua	ry 16,2006	Hanove	= M	(1)
Baltimore,			21. Signature of Funeral Service License		,		,				
ä	permit. Departrimports Imports any inju		1 Bile			22. Name and Addre	7522 6	ennelley D	rive so	te P.	
×.	4		23a. Part1. Enter the disease, or compli	cations that caused the dea	th. Do not	enter the mode of dy					Approximate
	Physician		shock, or heart failure. List only or tmmediate Cause (Final	ne cause on each line.	<						Interval Between Onset and Death
je	/Medical		disease or condition resulting in death)	Due to (or as a conse	guence of):						24 hours
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	D =	ner	Sequentially list conditions, to y leading the cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	quence of):						
1	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
8760,	cate be executed obysician and the burial-transit	ũ	resulting in deathly cast	Due to (or as a conse	quence of):						
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0	that ed b deta		Part II. Other significant conditions con	tributing to death but not re	sulting in the	underlying cause gi	ven in Part I.	23e. Did to	bacco use con	tribute to th	ne cause of death?
Vital Records,	The law requires ite has been signi age 2 should be	d by	Parkinson's	Disease.				1 🗆 Y	es 2 No	3 Prob	ably 4 Unknown
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\leq	Physician: this certific ral director,	OB	examiner? 1 ☐ Yes 2 🔀 No	lospital: 1 Inpatient 2	ER/Outpat	ient 3□ DOA Ot	nor	Home 5 Resid		ner (Snecifi	v)
J of		n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time	of 28c. Inju		28d. Describe h			//
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	ital o irs aft ral Di			\[\]							
	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th	ical	(Check only 2 Medical Examin	sician: To the best of my kn ner: On the basis of examin	owledge, de ation and/or	ath occurred at the tinvestigation, in my	me, date and place opinion, death occ	e, and due to the curred at the time, d	ause(s) and m	anner as st	tated. the cause(s)
	the thin 2 the mplet	Medic	one) 29b. Signature and title of certifier	and manner stated.		29c. Licen				_	
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	1041		30. Name and address of person who co	RKHIE	1810	PRINCE PRINCE	HILIP DI	2. OLN	EY, M	D Z	0832
	Sta	te	31. Date filed (Month, Day, Year)	32. gistrar's Sign					•		
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		•	Registrar 1. Decedent's Name (First, Middle,	Last)					2.	Date of Death		3. Time	of Death
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	edical mine		a. Facility Name (If not institution,	give street and numb	рөг)		4b. City, Town	, or Location	of Death		4c. County of		
		J	THE BROADMEAD						KEYSVI			BALTIMOR	
Fune		5		6. Sex 7	. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Day		24 Hrs. 8.	Date of Birth (Month, Day, Yo EC. 25, 1	9 001	Birthplace (State Country) AUSTRI	or Foreign
Direc	tor	-	218-22-4943 Usual Residence of Decedent	Χ.	104	115.			D.	EU. 25,1	901	AUSTRI	Α
/land low	4		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside	
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th the	l'ro'		10e. Street and Number				10f. Zip Code			10g	. Citizen of Wha		
ING Z1Z13-UU30 be filed within 72 hours after death with the Maryland tal Hygiene. d other then "neturel", or tems 23a or 28a-f show	Cinorial Director	8	13801 YORK ROA					210			14.5	USA	
er de.		ב	11. Marital Status	12. Was Deced	es?	5. 13.	Was Decedent of Yes, specify Co	f Hispanic Or uban, Mexica	rigin? (Specify n, Puerto Rica	y Yes or No- an, etc.)		American Indian, White, etc.	
rs aft	1	ý	1 ☐ Never Married 2 ☐ Marrie 3 🗖 Widowed 4 ☐ Divorced	ad 1 ☐ Yes 2 If Yes, Give Year or Dat	es:		1□Yes 2🎇 N	lo Specify	•		Specify:	WHIT	E
13-UUSO 72 hours at "neturel", or	Pot.		15. Decedent's	s Education		16a. Dece	dent's Usual Occ kind of work dor	cupation	et of working	16	b. Kind of Busir	ness/Industry	
thin 7	Completed	2	(Specify only highest Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use reti	ired)	at or working		JEWEL DV		
D D D		5				BOOK	KEEPER	10 14-16	and Name (C		JEWELRY	-	
			17. Father's Name (First, Middle, L (UNKNOWN)	.ast)		BAER			KNOWN)	irst, Middle, Ma	iden Surname)	(UNKNOW	N)
No I		2	19a. Informant's Name/Relationsh	ip (Type, Print)			ng Address (Stre		,	oute Number, C	ity or Town, St	·	
N Pd 2			GERALD MACKS /	COUSIN		3203	NORTHBI	ROOK R	OAD - I	BALTIMO	RE, MD	21208	
item		- 1	20a. Method of Disposition	- 50	20b. Pf	ace of Dispo	sition (Name of matory or other p	olace)	Date	20	c. Location - Ci	ty or Town, State	
Pages nent of l	2		1 X Burial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (Sp				AVAS CHI		01/19/	2006	RANDA	LLSTOWN,	MD
Baltimore, permit. Pages 1 a Department of Hee Importent: If Item	once.		21. Signature of Funeral Service-L	icensee			2. Name and Add					S., INC. E, MD 21	208
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that ca	used the death	. Do not ent	er the mode of d	lying, such as	s cardiac or re	spiratory arrest		Approxim Interval B	ate etween
Priyaic	ian :		Immediate Cause (Final disease or condition	,	Co	NERG	Tive :	Heart	Fai	ure	R	Onset and	d Death
/Medi			resulting in death)	Due to (c	r as a consequ								
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68 rtificat	as m	_	IF FEMALE.	T							1		
Records, P.O. Box 68/ The law requires that the death certificate the has been signed by the attending phy-	esn Jo		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		th 2 Fetal	death 3	∃Ectopic pregna				23d. Date of		Year
at the dea by the at	01 00 10	200	1 Tes 2 No 9 Unknown	4□Pregna 9□Unkno	nt at time of de wn	eath 5	Other (specify)						
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Of V Physici this ce	direc	0	examiner? 1 ☐ Yes 2 No	Hospital: 1 □ Ir	patient 2		nt 3 DOA	Other: 450 N	ursing Home	5 Residence	e 6 □Other	(Specify)	
Division of lor Attending Phy after death. Director: After this	unera		27. Manner of Death 1 Natural 5 Pending	28a. Date o (Month	f Injury n, Day Year)	28b. Time o Injury	V	ijury at Vork?	_	I. Describe how	injury occurred		
SIO tendi	the ft	Car	2 Accident investig 3 Suicide 6 Could n	ot bo	of taines. At he			☐ Yes 2 ☐		Location /Stree	at and Number	or Rural Route Nu	imber.
Z A	λqυ	Certification:	4 ☐ Homicide determi		g, etc. (Specify		reet, factory, offic	00	201.	City or Town,		OF THURSE FIODIG TAL	imber,
Div	0 6		29a. Certifier Scertifyin	g Physician: To the		tion and/or in			ath occurred	at the time, date			n(s)
B Hospitel or 24 hours after e Funerel Dire	etely filled i			Examiner: On the ba and mann	er stated.								,(3)
Division of Vita To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: Atter this certific	completely filled in	Medical	(Check only 2 Medical I	and mann	er stated.		29c. Lice	ense number	フマつ	290	. Date signed (Month, Day, Year)	
a	completely fill	Medical	(Check only 2 Medical I	and mann	er stated.	1 23a) (Type,	29c. Lice Print)	9 50	232	29d	Date signed (Month, Day, Year)	
To the Hospitel or, within 24 hours after To the Funerel Dire	completely fill	Medical	(Check only one) 2 Medical I are and title of certifies 30. Name and agreess of person	who completed cause	er stated. of death (Item	1 23a) (Type,	29c. Lice Print) Colleys	950 MLL	232 MS 2	1030	Date signed (Month, Day, Year)	
9	completely fill	Medical	(Check only one) 2 Medical I and title of certifies 30. Name and agoress of person (YU) HAM () 31. Date filed (Month, Day, Year)	who completed cause	or stated. or of death (Item Vofus gistrar's Signa	1 23a) (Type,	Print) CockEys	9 50	232 MS 2	29d	Date signed (Month, Day, Year,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#20b, perf H C9851 1/23/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE REHABILITATION OXIONOLD CARE 46 If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 6-16-1934 Days Hours Min. 10M 20F 246-42-7569 71 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "naturet", or Iteme 23a or 28a-f ehov emy hjury or other traumatic event, the Medical Examinar must be notified at once. Saltimore 1 Fryes 2 No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Bookert 45A Drive 21225 12. Was Decedent Ever in U.S. Armed Forces? 1 课程 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: à 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Transportation Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Long Shots Helen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, P 71115 Daughter Owing Mills My
20c. Location - City or Town, State 4706 Newtown Blud. 019 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/25/2006 B4/6, M1) Baltimore National 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Unighin C Greene Funer Senices 21. Signature of Funeral Service L Randellstown MD 21113 8728 Liberto 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner been signed by the attending physicien and should be detached for use as the burial-transit The law requires that the deeth certificate be exer Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 □ No 1 Yes 2 No To the Hospital or Attending Physician: ours after death.

nerel Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel [To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person RIVENBLYD BALTIMORE MD 21218 31. Date filed (Month, Day, Year) State JAN2 0 Registrar

			For State Registrar	Si	tate of	f Marylan		artment of F				giene () () (01090
			Decedent's Name (First, Middle	e, Last)							2. Date of Dea	ath		3. Time of Death
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)	/Medic Examin		4a. Facility Name (If not institutio					4b. City, Town, or	r Location	of Death		4c. County of	-	
		•	Howard County (Senera	l Ho	spital		Columb:	ia			Howard	Ē	
	Funeral		5. Social Security Number	6. Sex		7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under		8. Date of Birt	h s	9. Birthpl	ace (State or Foreign
	Director		053-30-5860	1 □ M	² ∏F	68	Yrs.	Months Days	Hours	Min.	(Month, Day Feb 26		New	York
	P .		Usual Residence of Decedent	·										
	arylar show	_	10a. State 10b. County	,		10c. City	, Town or Lo	cation					10	Od. Inside City Limits
	Ba-f	cto	Maryland Anne	Arund	lel	La	urel							1 ☐ Yes 2☐ No
	if th	Director	10e. Street and Number					10f. Zip Code				10g. Citizen of Wh	at Count	try?
	ath w 23a	- a	3573 Ft. Meade	Road	#20	9		20724	4			U.S.A.		
	tems rema	Funeral	11. Marital Status	1	Armed For		S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Ori an, Mexicar	igin? (Spe n, Puerto	cify Yes or No- Rican, etc.)	14. Race - Black.	America White, e	
36	be filed within 72 hours after death with the Maryland that Hyglene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examination must be notified at	by F	1 Never Married 2 Mar	1 1	1 ∐Yes If Yes, Giv	re		1 ☐ Yes 2 XX No	Specify:			Specify:	W]	nite
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an	d be softal	Be c	Michael Mauro						Rose			,		
<u> </u>	s 1 and 2 should be filed v I Health and Mental Hygie Item 27 Is marked other t other traumatic event, II	2	19a. Informant's Name/Relation:	ship (Type.	Print)		19b. Mailir	ng Address (Street				ar City or Town St	tate Zio	Code
Z	od 2 :		Nancy Lombardo		,	aughter		9 Ashford				Maryland		0707
ē	Hea Hea tem		20a. Method of Disposition		·	20b. P	lace of Dispo	sition (Name of	1		ate	20c. Location - C		
2	ages ent of t: If I		1 ☐ Burial 2XXCremation 1 ☐ Donation 5 ☐ Other (5		oval from S	State		matory`or other plac del Crema		1 /1 (/2006	Odontor	, M.	
Baltimore, Maryland 21215-0036	rtan rigur		21. Signature of Funeral Service			Wes	_					Odentor	1, 1410	aryiand
B	permit. Pages 1 and 2 Department of Health s Important: If Item 27 li any injury or other tra once.		1 G534		/ 1	M00770	3	Name and Addre Onaldson 13 Talbot	Fune:	ral E enue	Home, P. Laurel	.A. l, Maryla	and	20707
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п	/Medical		disease or condition resulting in death)	a		or as a consequ		-					- 60	3 DAYS
Ш	Examiner			Ι.	LV	NG	CAN	00552						9423
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Вох	ath ce ttend or use	an/	23b. Was decedent pregnant in the past 12 months?			come of pregna inth 2 Fetal		Ectopic pregnancy	,			23d. Date		•
-	the all	SCI	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		4□Pregn 9□Unkno	ant at time of do	eath 5	Other (specify)				Monti	1	Day Year
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S,	ires tha signed if be def	þ	Part II. Dther significant conditions and the significant conditions are significant conditions.	NIS CONTIDI	uting to de			onderlying cause giv	en in Parti	l ,		obacco use contrib	/	
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<u></u>		Ç											ath? ∃Yes :	2,2 No
Vital	ysiclan: Th is certificate director, pag	Be	25. Was case referred to medica examiner?		2. 1					e of Death	Check on o	ne		
		မ	1 Yes 2 No	Hosp	1 🕒 1		ER/Outpatier		4 LIN			dence 6 Other)
n	After Uner	on	27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	ng	8a. Date (/Mont	of Injury th, Day Year)	28b. Time o Injury	Wor			28d. Describe h	now injury occurred	1	
Sic	Attending r death. ector: After by the funer	cat	2 Accident invest	igation not be	- 51				Yes 2□	-				
Division of	Jor Al after of Direction by	Certification;	4 Homicide determ		buildii	ng, etc. (Specif)	ome, tarm, sti	eet, factory, office		1	City or Tow	Street and Number vn, State)	or Hural	Houte Number,
	lospital of hours a uneral D		29a. Certifier 1 ☐ Certifyi	ng Physicia	an: To the	best of my kno	wledge, deat	h occurred at the tir	ne, date ar	nd place, :	and due to the	cause(s) and man	ner as str	ated.
	T 4 IT 0	Medical	(Check only 2 Medica one)	Examiner:	On the ba	acis of examina ner stated.	tion and/or in	vestigation, in my o	pinion, dea	ath occurr	ed at the time,	date and place, an	d due to	the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certific	9	(/	// /	7 -	29c. Licens				29d. Date signed (
)	_/		- Cowald !	1 - 1 -	XV	eve X	IMI	018	45	7		TAN	, i	7 2006
	100		30. Name and address of persor	who compl	leted caus	se of de vh (Item	23a) (Type,	Print) /105	5 (ITT	LS F	ATUXS!	UT	PKWIS
_	12		EDNARD S	CHA	EFE	-RIM	D	coci	inis	in.	MA	Rycan	7	7 2006 PKWY 21044
	Sta		31. Date filed (Month, Day, Year)	32. R	egistrar's Signa	ture	AP 2						
	Regist	ar	JAN 2 C	2006		Sec of Sec	STATE OF THE PARTY							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#18,perffl, (851, 1/23/06 TI)
State of Maryland / Department of Health and Mental Hygiene
State of Maryland / Department of Department of Health and Mental Hygiene
1- For Amend Item 23a per Dr., (851, 01/20/00dh)
Registrer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#18,perffl, (851, 1/23/06 TI)
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Morrison 7:55 Sylvia January 01 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Mercy medical Center Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Age (In yrs. last birthday) Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/01/1923 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 82 1 ☐ M 2 X F 234-30-1856 West Virginia Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County r 28a-f show 1 ¥Yes 2 □ No N/A Baltimore City Directo Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "natural", or Itama 23a or the Medical Examiner must be United States 21231 608 S. Washington Street death Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) be filed within 72 hours after dutal Hygiene. d other than "natural", or Itam 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental H sant: If itam 27 is marked other. Byrd Helmick Hattie Keyser V. Amie ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other trat once. Virginia Kutrick - Daughter 442 Machias Place Middle River, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 01/06/2006 Baltimore, Maryland Oak Lawn Cemetery David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 21. Signature of Funeral Service, 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Stage 4 Kidney Disease Approximate fnterval Between Onset and Death Immediate Cause (Finaf Renal Farluve Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Diabetes Mellitus Esqueritary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit certificate be executed Hypertension resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy has 1 Yes this certificate 2 No 1 ☐ Yes Division of Vital : After this certification and funeral director. Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Nio 1 Inpatient 2 ER/Outpatient 3 DOA ပ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier A 44176435515888 January 01 10 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) saint Place 36 i Paul Balhmore, MD 21202 Rachel Sali 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 0 2006

Registrar

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			For Stata Registrar	State of Mary	,	ertificate o		vicillai i	Reg. N	2 U U	6 0109	92
			Decedent's Name (First, Middle, La	st)				2. Date of	Death		3. Time of D	eath)
A.	Physici	_	PATRICIA	ANN	MI	LLER		Hance			006 9:30	AM
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)			n, or Location of Death	· · ·	4	c. County of	Death	
			Sinai Hospite	i of Boetin	nore	Belt	imore ce	75		NIA	4	
14	Funeral		5. Social Security Number 6. S		In yrs. last birthday	/ Il Under 1 Ye Months Da		(Month,	Birth Day, Yea	r) s	Birthplace (State or i Country)	Foreign
	Director	-	216-40-01/5	5c) Yrs.			FORUM	7RY 10	1953 N	JORTH CARDA	LINA
	and and	1	Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or I	ocation					10d. Inside City	Limits
	Manyl	ŏ	MARYLAND NIA		BALTI	MORE	CITY				1 SYYes 2	2 🗌 No
	r 28a-f ehow	Director	10e. Street and Number		<u></u>	10f. Zip Cod			10g. C	itizen of Wh	at Country?	
	deeth with the Maryland ms 23a or 28a-f ehow must be notified at		3708 W.BE	LVEDERE	AVENU	E 210	215		0	SIA		
	deeti	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?			ol Hispanic Origin? (S Juban, Mexican, Puert	pecify Yes or	No-		American Indian, White, etc.	
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93	hours after tural', or Ite al Examine	d by	3 Widowed 4 Divorced	Year or Dates:							BLACK	
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2	hould be filed within Id Mental Hygiene. marked other then matic event, the Men	ပိ	17 GRADE 17. Father's Name (First, Middle, Last)	//	11/6/1/	18. Mother's Nar	ne (First, Mid				
ano) Be	OTHO		LER		MARIE		/	PAIT	WELL	
Maryland	s 1 and 2 should be f Health and Mental from 27 ie marked o other treumatic eve	2	19a. Informant's Name/Relationship			ling Address (Str	eet and Number or Ru					
≥	DENE		MARIEA MILL	ER (DANGH	TER 370	810.3	FIVEDERE	AVE	BAL	TIMO	eE.MD 21	215
ē,	Health tem 27 other tr		20a. Method of Disposition		20b. Place of Disp			Date			ity or Town, State	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 eny Injury or other once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		METRO			0-200	1. BA	PLTIN	ORE, MAK	YLANT.
量	Departme Departme Importar eny Injue once.		21. Signature of Funeral Service Lice		1 10	22. Name and Ad	dress of Facility	/ -		-001	HOME.	
ä	Depa Impo		Watrich	N. Will	warro 3	141) N. F	H. BRUCE	PAIT	FUNI	EKAL EN	HOME D 21217	7
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	aplications that caused th	e death. Do not e	nter the mode of	dying, such as cardiad	or respirator	y arrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final	Acute	GONTRO	intestin	ol Blee				Onset and De	eath
	/Medical		disease or condition resulting in death)	Due to (or as a c		7771-7.1.					12100	
	Examiner		2-7-10-1-17-18-1	b								
-		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequençe ol):							
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0,			resulting in death) Last	Due to (or as a c	consequence of):							
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x 68	Attending Physician: The law requires that the death certifical rideath. sctor: Atter this certificete hes been signed by the attending phy the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE:	23c. If yes, outcome of	0.0000000							
Bo	attenc for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 (4 Pregnant at tin	Fetal death 3	☐Ectopic pregna				23d. Date Monti		ear
Ö	the de	ysic	1 ☐ Yes 2-1 ☐ No 9 ☐ Unknown	9☐ Unknown	ne or death 5	□ Other (specify	/	· · · · · · · · · · · · · · · · · · ·	-			
σ.	that the ed by detac	윤	Part II. Other significant conditions	contributing to death but i	not resulting in the	underlying cause	grven in Part I.	23e. D	id tobacco	use contrib	ute to the cause of de	ath?
ds	w requires that been signed b should be deta	d b	Hypertansion					1	Yes	2 □ No 3	Probably 4 Un	nknown
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co.	n: Ti		25. Was case referred to medical	1			26. Place of Dea	1 Ye		No 1L	Yes 25 No	
₹	Physician: The lav this certificete hes at director, page 2	o Be	examiner?	Hospital: 1 Unpatient	2 ER/Outpati	ent 3 DOA	Other: 4 Nursing H			6 □Other	(Spacific)	
o	Phy or this oral d	=	27. Manner of Death	28a. Date of Injury (Month, Day Y		ol 28c. l	njury at	,		ury occurred		
lo	nding ath. r: Afte e fun	atio	1 Natural 5 Pending 2 Accident investigation		(ear) Injury		Work? 1 ∐ Yes 2 ∐ No					
Division of Vital Records, P.O. Box	Atte	Hic	3 ☐ Suicide 6 ☐ Could not 8 4 ☐ Homicide determined		- At home, larm,	street, lactory, off	ice	28f. Locatio	n (Street Town, Sta	and Number	or Rural Route Numb	ΘΓ,
Ö	s afte	Certification; To	4 El Hornolda	building, etc.	(эрвену)			ony or	701111, 010			
	hour hour uner		29a. Certifier 1 Certifying P	hysician: To the best of miner: On the basis of e	my knowledge, de	ath occurred at th	e time, date and place	, and due to	the cause	(s) and man	ner as stated.	
	To the Hospitel or Attending Physician: The lar within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Medical	one)	and manner state	id.			ined at the til				
	With To T	Σ	29b. Signature and title of certifier	. 1 . 1 .			cense number				(Month, Day, Year)	
			* Produce		MID	K	=> -08		1301	nuery	16,2006	
	1		30. Name and address of person who	completed cause of dea		e, Print)	no: Unc	itae	of	2005	16,2006	
	1		31. Date filed (Month, Day, Year)	32. P (sistrar)	s Signature	0	riw riusp	1190	1! /	02(1/1	1010	
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Patient wown

		1	For State Registrar	State of Ma	ryland			nt of He te of D		ind M	ental Hy	6) (01093
	.*		Hegistrar Decedent's Name (First, Middle, Last)			007	incai	.0 01 2	Catri		2. Date of D				3. Time of Death
¥	Physici		Terry			MaZ	Paniel				Month Ja.	Da	5 20		19:25 M
	/Medic Examin	_	4a. Facility Name (If not institution, give st				-	Town, or L		Death			. County of D		
		4	Oniversity of Marylers 5. Social Security Number 6. Sex		Cente	مر (st birthday		r 1 Year	II Under 2	24 Hrs.	8. Date of B	irth	0	Distholo	ce (State or Foreign
	Funeral Director			M 2□F	47	Yrs.	Months		Hours	Min.	MAR"	2'5 ^{Year}	958	Country	MD
4	ը ,		Usual Residence of Decedent												
	anylar ehow	_	MD 10b. County N/A		10c. City,	Town or Lo	cation imore	^						100	I. Inside City Limits 1 Yes 2 No
	28e-1	Director	10e. Street and Number			Dail		Code	· · · · · ·			100 Ci	izen of What	Count	
	3a or		501 W. Franklin	Street				21201				10g. 01	USA	Country	<i>y</i> :
	death rma 2:	nera		2. Was Decedent E	ver in U.S	. 13. \	Was Dece	dent of His	panic Orig	in? (Spe	cify Yes or N	0-	14. Race - A		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or itema 23a or 28e-f show any injury or other traumatic event, the Medical Exeminer must be notified at once.	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give	0		i res, spe i⊡ Yes	-	Specify:	, Риело і	Rican, etc.)		Black, W Specify:		ite
21215-0036	tural	ed b	15. Decedent's Educa	Year or Dates:		16a. Deced	dent's Usu	al Occupat	ion			16b K	ind of Busine		
215	nin 72 In "na Medis	Completed	(Specify only highest grade Elementary/Secondary (0-12)			(Give	kind of wo	ork done du se retired)		of workii	ng	100.1	and or bosing	33/11/00	stry
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7	d Mer narke	2	Willard McDanie 19a. Informant's Name/Relationship (Type			10h Mallia		/C*		lyn		berg		7: 0	- 4-3
Ma	ith an 27 is s traur	li j	Laurie Cline - Guar				-				re. M		or Town, State 212	e, <i>zip</i> C	008)
ē,	s 1 ar		20a. Method of Disposition		20b. Pla	ice of Dispo	sition (Na	me of	-		ate	,	ocation - City	or Town	n, State
altimore,	Pages nent of I ant: If It ary or o		1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State		wood	_			/23/	2006	Ba1	timore	. M	D
	permit. Departn Imports any Inju		21. Signature of Funeral Service Licensee			22 C	Name ar Δ F Δ	nd Address	ol Facility	Ic	hrmanr				
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F			23a. Part 1. Enter the disease, or complice shock, or heart lailure. List only one	ations that caused to cause on each line	the death.	Do not enti	er the mod	de of dying,	such as o	cardiac o	r respiratory a	arrest,		l A	pproximate hterval Between Inset and Death
And the	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	51	Ele	evation	n A	1 your	dial	Inf.	arction				
	Examiner			Due to (or as a	conseque	ence of):	6	V V -	٦.						
E		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	conseque	ence of):		05tm	recor	<u> </u>					
	icate be executed physicien and the burial-transit	Examiner	that initiated events												
60,	be execien a	al Ex	resulting in death) Last	Due to (or as a	conseque	ence ol):									
8760	physicate t	g	d.											-	-
Box (certifi nding use at	√Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome o									23d. Date of	delivery	
m̃.	es that the death certifi igned by the attending be detached for use as	by Physician/Me	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti			Ectopic p Other (sp						Month	D	ay Year
P.O.	at the	hys	9 🗆 Unknown	9□ Unknown											
	The law requires that the death certifie has been signed by the attending toge 2 should be detached for use as		Part II. Other significant conditions control	-		ting in the ur	nderlying o	ause given	in Part I.						cause of death?
Ö	w require been sig should b	eted	Coronary Antery	Disease	7	Hype	-tensi	,00					Ø No 3 □	Probab	ly 4 □Unknown
Rec	hysician: The law his certificete has t I director, pege 2 s	Completed	Congestive Heart	taikine,	Hypi	erchole	sterol	emia			24a. Was		24b. Were prior death	to comp	y findings available letion of cause of
<u>a</u>	in: Th	ပိ	25. Was case referred to medical								1 ☐ Yes	2 1 No			No No
5	ysicia s cert direct	To B	examiner?	spital:	t 2∏F	R/Outpatien	t 3 🗍 DC	Other			(Check only		6	'acciful	
ō	ding Phy h. After thi funeral o	T:u	27. Manner ol Death	28a. Date of Injury	, 2	28b. Time of		28c. Injury a Work?	at		8d. Describe			респу	
S	endin eath. or: Af he fur	atic	1 Pending 2 Accident 5 Pending investigation	(Mornin, Day	7047		м		es 2□N	10					
Division of Vital Records,	To the Hospital or Attending Physician: within 42 hours after death To the Funeral Director: After this certifice completely filled in by the funeral director; g	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At hom (Specify)	ne, farm, stre	et, factor	y, office		2	281. Location City or To	(Street ar wn, State	nd Number or a)	Rural F	loute Number,
	spital hours neral / filled	a	29a. Certifier 1 Certifying Physic	cian: To the best of	my know	ledge, death	occurred	at the time	, date and	place, a	ind due to the	cause(s	and manner	as state	ed.
	he Hc in 24 he Fu pletely	edicai	(Check only 2 Medical Examine one)	r: On the basis of e and manner state	examinatio	on and/or inv	estigation	, in my opir	nion, deatl	h occurre	ed at the time	date and	d place, and o	due to th	e cause(s)
	To t To t	Σ	29b. Signature and title of certifier				290	c. License		011			te signed (Mo		
dan	0		1111	7				F	196	74			January	15,	200%
2			30. Name and address of person who com	and the second				à	71	1.	4.8				
	Sta	te	Thilip C. Dittmer MD. 31. Date filed (Nighth, Day, Year)	32. Registrar		reene	Str	est	Do. l	time	e, MD				
P _{ig}	Registr		JMN & U 2006	Addition to	A Sing	ST. 1884	and the same								

		•	1 - State of Maryland / Dep	partment of He e <i>rtificate of D</i>			iene 006	01094
1	d		1. Decedent's Name (First, Middle, Last)			2. Date of Deat	ih Day Year	3. Time of Death
	Physici /Medic		Archie Mac Murray			January	13 200	*
A. V	Examin	er	4a. Facility Name (If not institution, give street and number) SAINT AGNES HOSPITAL	4b. City, Town, or Baut	more		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthda 50 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 1	Year) C	thplace (State or Foreign ountry) Yland
	ow ow		10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits
	death with the Maryland rms 23a or 28a-f ehow rmsi ke nutified at	Ď	Maryland Anne Arundel Glen B	urnie				1 ☐ Yes 2X No
	or 28	Directo	10e. Street and Number	10f. Zip Code		1	0g. Citizen of What C	ountry?
	ath w		8006 Solley Rd.	21060			USA	
326	be filed within 72 hours after death with the Marylan tal Hygiene. d other then "netural", or items 23s or 28s-1 ehow event, the Medical Exprimer must be putitied at	by Funeral	11. Marital Status 1. Marital Status 1. Mas Decedent Ever in U.S. Armed Forces?	 Was Decedent of His If Yes, specify Cubar 1 ☐ Yes XXNo 	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: B	ite, etc.
15-0036	72 ho	ted	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupa ive kind of work done do	tion	ana	16b. Kind of Business	s/Industry
21	ithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	 DO NOT use retired) 	aring most or work		IIia. D	
2	led w tygier ther th		1201	Mechanic	19 Mothods Nam		United Ro	entals
Maryland		Be	17. Father's Name (First, Middle, Last) Elmer Murray		Florence			
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_	and 2 she salth and n 27 le m	1	Roger L Murray Sr.(Brother) 320	-			va, Md.	
altimore,	Hear Hear Hear Hear Hear Hear Othe			sposition (Name of	ah-	Date	20c. Location - City o	r Town, State
Ë			1 A Burial 2 Cremation 3 Removal from State A S がせかく UMC Ce			0-06	Annapoli:	s, Md.
Balti	permit. Pages Depertment of Important: If I eny injury or ance.		21. Signature of Funeral Service Licensee Zarry B, Reese MOOF 83	Wm ^{Name} Readdes 821 West	Sof & Sons	Mortu napolis	ary, P.A , Md. 21	401
£6	Physician /Medical Examiner	Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events)	Reumani	, such as cardiac	or respiratory arr	esi,	Approximate Interval Between Ogset and Death Lay
8760,	icate be executed physicien and s the burial-transit	dical Ex	resulting in death) Last Due to (or as a consequence of): d					
P.O. Box 6	The law requires that the death certificate be executed at hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med		3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of de Month	alivery Day Year
	quires that n signed b	ρ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause give	on in Part I.		bacco use contribute es 2 ☐ No 3 ☐ F	to the cause of death? Probably 4 Munknown
Division of Vital Records,	The law requirate hes been si page 2 should I	Completed				24a. Was a autop: perfor	sy prior to med? death?	autopsy findings available completion of cause of s 2 No
ita	clan: ertific actor.	Be	25. Was case referred to medical examiner?			th (Check only or	76)	
5	shysi this c	2	1 Yes 2 No Hospital: 1 patient 2 ER/Outpa		4 Nursing n		ence 6 Other (Sp	ecify)
sion (Attending Physician: or death. ector: After this certifice by the funeral director. I	Certification;	27. Manner of Death 1 XNatural 5 Pending investigation 3 Suicide 6 Could not be 389. Place of Injury (Month, Day Year) 28b. Time (Month, Day Year) 28b. Time (Month, Day Year)	ry Work M 1 □ Y	at :? /es 2 □ No		ow injury occurred	Translation of the Atlanta
Dİ	urs efter or Al Director or Al Direc		4 Homicide determined 256. Place of injury - Actions, family building, etc. (Specify)	•		City or Tow		
	To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) (Check one) (Check only one) (Check only one) (Check only one) (Check one	eath occurred at the tim r investigation, in my op 29c. License	pinion, death occu	rred at the time, o	date and place, and du	e to the cause(s)
)	T IN S		29b. Signature and title of certifier Medical doctor	P195	_	-	Tanuary 13	2006
1	2		30. Name and address of person who completed cause of death (Item 23a) (Type 200 Codes and 200 Codes		imore.	21220	0	
4	St. Regist	ate	31. Date filed (Month, Day, Yel) 32. Registrar's Signature	rive Dall	n more	~ 1~~7		
DI	IMH 17 Rev 1/2	- 4	JAM 2 9 Allio Alexander of Party	m2 5				

DHMH 17 Rev 1/2001

BLAKE MORGAN 06-00382 Unpend item#23, PI, 27, pend 1, 27, pend 1 RKD State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Blake A. Morgan JANUARY 15 2006 8:25A. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner ANNAPOLIS

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | Nov 24 ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**X**0 M 2□ F 220-82-4752 37 Yrs. 1968 Maryland Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a State il Hygiene. lother then "naturel", or iteme 23e or 26e-f ehow ivent, the Mudical Examiner must be notified at TXTX es 2 □ No Maryland Anne Arundel Annapolis Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21401 401 Oaklawn Ave Completed by Funeral death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☐ Yoo Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Restaurant Cook permit. Pages 1 and 2 should be filed v Deportment of Health and Mental Hygie Important: If Item 27 is marked other It any injury or other traumatic avent. IIIs ONCE. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maryland Morgan James Harris 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 401 Oaklawn Ave Annapolis, Md. 21401 James Harris(Father) 20c. Location - City or Town, State 20b. Place of Disposition (Name of Best grant and the Name of Disposition (Name of Disposition) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1-20-06 Park Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) Wm. Reese & Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses Zanny 5 face 10048 821 West St. Annapolis,
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dilated Cardiomyopathy **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien end for use as the burial-transit certificate be executed Due to (or as a consequence of). Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. I ☐Yes 2☐No the 6 detached 9 Unknown ate has been signed by a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ğ 1 Tes 2 No 3 Probably 4 Unknown Cocaine use Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No autopsy performed innel Director; After this certificate has filled in by the funeral director, page 2 Yes 2 No 2 🗆 No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Clieck only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 2 No 2 ER/Outpatient ဥ 1 Yes 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury Division 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide efter ŏ within 24 hours 6 To the Funeral L Certifying Physician: Tu the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Physician: To the best of Try knowledge death occurred at the time data and place. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 23a, Cartille Medical To the 29d. Date signed (Month, Day, Year) 29c. License number certifier 29b. Signatore a title o O.C.M.E. JANUARY 16, 2006 who completed cause of death (Item 23a) (Type, Print) PENN STREET BALTIMORE, MARYLAND 21201

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 0

2006

ORIGINAL

South

32 Registrar's Signature

		•	For State Registrar	State of Mai		artment of rtificate of		ind Mental F	lygiene	UU0	01096
			1. Decedent's Name (First, Middle, Las	0		-		2. Date of Month	Death		3. Time of Death
	Physicia /Medic		William]	McKee			Jan	uarg	4, 200	6 0520 m
	Examin		4a. Facility Name (If not institution, give UNION HOSI	Street and number)		4b. City, Town,		f Death		County of Dea	th
	Funeral Director		169-20-6282	7. Age	(In yrs. last birthday 77 Yrs.	Months Days		Min. (Month,	Birth <i>Day, Year)</i> B ,192 8	C	thplace (State or Foreign ountry) K
	land	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
:	Mary -1 sh	ţ	Maryland Cecil		E1kton						1 □ Yes 2 📉 No
	r 28a	Director	10e. Street and Number		<u> </u>	10f. Zip Code		· · · · · · · · · · · · · · · · · · ·	10g. Citi	izen of What Co	ountry?
	23a o	aiD	100 Laurel Drive			2192	1		Uni	ited Sta	ates
	ems ems	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of	Hispanic Original	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame Black, Whi	
36	or It	by Fu	1 ★ Never Married 2 Married	1 □Yes 2 2 No If Yes, Give		1 ☐ Yes 2 ☑ No		,			hite
0	within 72 hours atter death with the Maryland ene. Than "natural", or Items 23e or 28e-f show he Medical Examinar must be notitled at	g p	3 Widowed 4 Divorced	Year or Dates:	160 Dec	edent's Usual Occi			105 10		
7	in 72 in 72	Completed	15. Decedent's Ed (Specify onfy highest grad	de completed)	(Give	kind of work done DO NOT use retir	e during most	of working	160. KI	ind of Business	Andustry
712	f with jene.	E O	Elementary/Secondary (0-12) unk	College (1-4or 5+)	nk			unk	r	
פַ	othe	BeC	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name (First, Mide			
/lar	uld by Wenta Irked	To E	unk				unk				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inpartment of Health and Mental Hygiene. In the Marylan I if them 27 la marked other than "natural", or Items 20a or 28a-1 show any Injury or other traumatic event, the Medical Examinal must be notified at once.		19a. Informant's Name/Relationship (7					r or Rural Route Nur		r Town, State,	Zip Code)
ر م	and fealth m 27 her tr	1	Michele Adams, Ho	spital Adm		and the latest and th	et, Ell	kton, Mary			
altimore,	ges 1 nt of F nt of F if ite or ot		20a. Method of Disposition 1		20b. Place of Disp cemetery, cre	osition (Name of Imatory of other pl Cemetery	lace)	Date n 17 200		cation - City or	Maryland
Ħ.	it. Pa rtmen rtant: njury		' 4 ☐ Donation 5 ☐ Other (Specify			_	i				
Ba	Depa Impo any Ir once		21. Stranger Licen	T. Harman M				Asrian T. U A. d, Timonium			Services of
Ι.			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	plications that caused to one cause on each line	he death. Do not er	iter the mode of dy	ying, such as	cardiac or respirator	y arrest,		Approximate Interval Between
	nysician		Immediate Cause (Final disease or condition	a. PNE	UMON	11A.					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):						
10		_	Saguentially list conditions	b. Due to or as a	consequence of):						
	rted nsit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Chlo	NIC (R STR 110	TIVE	PULMO	MARY	DICE AL	C
<u>_</u>	execu n and ial-tra	Exai	that initiated events resulting in death) Last	C. Due to (or as a	consequence of):	03/10		100.10	· · · · · · · · · · · · · · · · · · ·	VISEIN	<u> </u>
8760,	cate be executed physician and the burial-transit	dicai		d							
68	fiffical ng phy as th	0									
Вох	death certifi e attending od for use as	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1□Live birth 2		⊒Ectopic pregnan	cv		1	23d. Date of de	,
O	that the death certifi ed by the attending p detached for use as	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at ti 9□Unknown		Other (specify)		·	-	Month	Day Year
P.	that the ed by th detache		Part II. Other significant conditions or	antributing to death but	not resulting in the	inderhing eques o	viuon in Bart I	23a D	id tobacco u	una contributa t	the cause of death?
ds,	ires tha signed d be del	d by	Tarris office organization of	online and to detail but	not resulting in the	andenying cadse y	pvom ni raiti.		□Yes 21		robably 4 Onknown
Sor	been s	ete						24a. W	-		
Re	The law requires ate has been sign page 2 should be	ompleted						au	itopsy orformed?	prior to death?	utopsy findings available completion of cause of
tal	10	O O	25. Was case referred to medical				26 Plans	1 Test		1 ☐ Yes	2 No
>	Phyalcian: this certific ral director,	OB	examiner? 1 □ Yes 2 ☑ No	Hospital: 1 Inpatient	t 2 ER/Outpatie	nt 3 DOA	than	of Death Check on sing Home 5 R		6 □Other (Spe	ocifu)
10		T:U	27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time			28d. Describ			ony,
Sion	Attending r death. ector: After by the fune	atic	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		,,		Yes 2□N	10			
	or Attendation of Attendation of Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, s (Specify)	reet, factory, office	9		n (Street an Town, State		ural Route Number,
	pital ours a eral D		200 Conflict	volcion T- 15	mulmania d	Ab 1 :::	4:	Latina in the same of the same			
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of iner: On the basis of e and manner state	examination and/or i	th occurred at the nvestigation, in my	time, date and opinion, deat	d place, and due to the control of t	he cause(s) ne, date and	and manner as I place, and due	s stated. e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier)		29c. Licer	nse number	Q	29d. Dat	e signed (Mont	th, Day, Year)
}			Hortman			V5	127	0	Jay	1 04)	2000.
			30. Name and address of person who of ALOK RUSTOG		ath (Item 23a) (Type	Print)	PITA	1 61	VTA	N ME	HAYLAND.
	-61			32. Registrar		N (103	71117	- 120	10	14 / 14/	VICHTIND.
	Sta Registi		31. Date filed (Month, Day, Year)	Electron A	4 Somet	5					

MCKEE, WILLIAM

			For State Registrar	State of Mary		artment of F			ene () () 6 g. No.	01097
- 2	District.		1. Decedent's Name (First, Middle, La					Date of Death Month	Day Year	3. Time of Death
	Physici /Medic	100	Anna Mari	e Martind	ale	,		January	18 2006	
	Examin		4a. Facility Name (If not institution, gir				r Location of Death		4c. County of Dea	
			9812 Philadelph				ltimore	0.0	Baltim	
	Funeral Director			Sex 7. Age (II 1 ☐ M 2 ဩ F	n yrs. last birthday, 88 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Feb. 12	1917 9. Bir	thplace (State or Foreign puntry)
	면 .		Usual Residence of Decedent	4/	o City Town and					10d. Inside City Limits
	d within 72 hours after death with the Maryland jiene. r than "natural", or Items 23a or 28a-f show the Medical Examinar must be netified at	o	Maryland Balt	timore	oc. City, Town or L		altimore			1 ☐ Yes 2X No
	28a-	Funeral Director	10e. Street and Number	or more		10f. Zip Code	a i b i i i o i c	10	g. Citizen of What Co	ountry?
	3a or	<u>-</u>	9812 Philadelph	ia Road			21237		USA	
	deatl	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of H	dispanic Origin? (Span Mayican Puert	pecify Yes or No-	14. Race - Ame Black, Whit	
92	or Ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No		1 ☐ Yes 2 ☒ No	Specify:	7 110211, 010.)		White
Ö	hours turat',	ed by	3	Year or Dates:	16a Dece	dent's Usual Occup	nation	1	6b. Kind of Business	/Industry
15	in 72 n *na hadic	Completed	(Specify only highest gi	ade completed)	(Give	kind of work done DO NOT use retire	during most of word d)	king		
212	d within piene. r than	E	Elementary/Secondary (0-12)	College (1-4or 5+)	ŀ	Homemaker			Househo	1d
bu	be filed tal Hygid d other event, I	Bec	17. Father's Name (First, Middle, Las					ne (First, Middle, M		
Maryland 21215-0036		2		ocak			Anna	Zuzor		
Mar	s 1 and 2 should I Health and Mer Item 27 Is marke other traumatic	l i	19a. Informant's Name/Relationship						City or Town, State,	
	s 1 and f Healt item 2 other		Dorothy Woods 20a. Method of Disposition	(daughter)	20b. Place of Disp	osition (Name of			nore, MD 2	
nor	000===		1 XBurial 2 ☐ Cremation 3 (4 ☐ Donation 5 ☐ Other (Spec			en Cemete		23		e, Maryland
Baltimore,	교육관금 .		21. Signature of Funeral Service Use	the state of the s		W				
Ba	Derm Depa Impo		Muchell	Stalle	x A					Home, P.A. 1122
			23a. Part1. Enter the disease, or conshock, or heart failure. List on	y one cause on each line.		ter the mode of dyir	ng, such as cardiac		st,	Approximate Interval Between Onset and Death
1 200	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a c	ranc	Jerry				
198	Examiner				onsequence or).					
- 50	D ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):					
	and and il-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c	onsequence of):					
8760,	sician a			200 10 (01 23 2 0	5/135qu5/165 5/ ₇ .					
687	ificate I g physical as the b	edic		a						
Вох	eath certific attending p for use as	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of a		□Ectopic pregnanc			23d. Date of de	livery
). B	it the deat by the attr tached for	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at tim		Other (specify)	у		Month	Day Year
P.0	hat th ed by detach		Part II. Other significant conditions	contributing to death but r	not resulting in the	underlying cause giv	ven in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
Vital Records,	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	d by						1 ☐ Ye	s 2□No 3□P	robably 4 Minknown
000	aw requ s been 2 shoul	Completed						24a. Was an		utopsy findings available
R	The la	E O						autopsy perform	ed? death?	completion of cause of
ita	ician: Th certificete ector, pag	BeC	25. Was case referred to medical				26. Place of Dea	th (Check only one		
>	di S	2	examiner? 1 Tes 2 To	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3□ DOA Ott	ner: 4 Nursing H	ome 5 Resider	nce 6 Other (Spe	ecify)
	ding Ph th. After th tuneral		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time	Wo		28d. Describe ho	w injury occurred	
sio	r Attending er death. rector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not	bo .			Yes 2 □ No	00/ 1 /0-		
Division	after of Direct Direct In by	Certification:	4 Homicide determine		- At nome, tarm, s Specify)	treet, lactory, office		City or Town,	eet and Number or R , State)	urai Houte Number,
	spita nours naral		29a. Certifier 1 Certifying F	hysician: To the best of r	ny knowledge, dea	th occurred at the ti	me, date and place	, and due to the ca	use(s) and manner a	s stated.
	To the Hospital or Attant within 24 hours after deatl To the Funaral Director: completely filled in by the	Medical	one)	miner: On the basis of ex and marrier states	d.				, ,	
	To T	2	29b. Signature and title of certifier	M RIN	66	29c. Licens	se number	29	d. Date signed (Mon	th, Day, Year)
	\				h /ltom CCo\ /T	Print)		3	Dur	
			30. Name and address of person who	completed cause of deat	n (Item 23a) (Type	29c. Licens	NATON	196818	INIUE -	
		áte	31. Date filed (Month, Day, Year)	32. Hegistrar's	Signature	will.				
	Regist	rar	JAN 2 0	2006	, So As					

		For State Registrar	State of Mai	-	epartment o		and Mental Hy	giene Reg. No. 006	01098
Physic	20	1. Decedent's Name (First, Middle, Last)			\sim	11	2. Date of De Month	aath Day Year	3. Time of Death
/Medi	cal	Robert			Mac		January	4c. County of Dea	
Exami	ner	4a. Facility Neme (If not institution, give s		11 . 1	/	vn, or Location	3. 1	4c. County of Dea	atri
Funeral		5. Social Security Number 6. Sex	OP Kins 7. Age	(In yrs. last birth	day) If Under 1 Y	ear If Under	24 Hrs. 8 Date of Bir	th 9. Bi	rthplace (State or Foreign
Director		213–32–1569 ¹ X	M 2□F	71 Y	rs. Months D	ays Hours	Min. (Month, Da 5-3-1	934 MA	RYLAND
2 3		Usual Residence of Decedent 10a. Slate 10b. County		10c. City, Town	or Location				10d. Inside City Limits
Aaryla f eho	ō	MD BALTI				ROSEDA	LE		1 ☐ Yes 2X No
the A	Director	10e. Street and Number			10f. Zip Co	de		10g. Citizen of What C	ountry?
h with	I D	7905 DALROSE AVEN	UE			21237		U.S.	Α.
deat	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. Was Decedent	of Hispanic Or Cuban, Mexica	igin? (Specify Yes or Non, Puerto Rican, etc.)	14. Race - Am Black, Wh	
36 s afte	by Fu	1 ☐ Never Married 21 Married 3 ☐ Widowed 4 ☐ Divorced	1 □X es 2 □ No If Yes, Give	CODEIAN	1 ☐ Yes 2 ☐			Specify:	WHITE
21215-0036 ad within 72 hours after death with the Maryland glane. er then "natural", or iteme 23e or 28e-f ehow it, the Medical Examinet must be notified at		15. Decedent's Edu	Year or Dates:]	16a. l	Decedeni's Usual O	ccupation		16b. Kind of Business	
within 72 see.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+		Give kind of work of life. DO NOT use n	lone during mos etired)	st of working		
d 212 filed with Hygiene. rther thei	S	12		<u></u>	MANAGE			GREENSPR1	NG DAIRY
S d is b S	Be	17. Father's Name (First, Middle, Last)					er's Name <i>(First, Middl</i> e DANICEC		
Maryla d 2 should the and Ment T is marked traumatics	ုင	HENRY MACK 19a. Informant's Name/Relationship (Ty		19b	Mailing Address (S		RANCES er or Rural Route Numb	(POTTER)	Zin Code)
Mar nd 2 sho alth and 27 is my		DOROTHY MACK/WIFE			05 DALRO				21237
	-1	20a. Method of Disposition		20b. Place of cemeters	Disposition (Name of crematory or other	of r place)	Date	20c. Location - City o	r Town, Slate
altimore, mit. Pages 1 a partment of Her portant: if Item y Injury or others.		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State				1–19–2006	OWING MILI	LS, MD
Baltimo permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service License	96		22. Name and A		TY CVACH / ROS	EDALE FUNER EDALE, MD	RAL HOME 21237
TOP		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	cations lhat caused t le cause on each line	he death. Do n	ot enter the mode of	f dying, such as	cardiac or respiratory a	rrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Care	diomy.	pathy				Onset and Death
/Medical Examiner		resulting in death)							7
CAUTIMIET	<u></u>	Sequentially list conditions,		consequence o	: br; 11a	tion			10 4195
De in the transfer of the tran	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	7	ia be T					10 40018
'60, Control of the executed sicien and burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a	consequence o	r):				70 9 101.0
Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transl	dlcal			25 + V.	entricu	ki 1	Thrombi		10 41arx
K 68 entifica	Med	IF FEMALE:	0. 11						
Box 68 leath certific:	Physician/Me	in the past 12 months?	3c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death	3 ☐Ectopic pregr			23d. Date of de Month	Day Year
P.O. hat the de deby the detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	ine or death	3 Li Other (specii	<i>y</i> /			
S, P, es that	by Ph	Part II. Other significant conditions con	tributing to death but	t not resulting in	the underlying caus	e given in Part	I. 23e. Did	tobacco use contribute	to the cause of death?
Cords, requires							1,200	Yes 2□No 3□F	Probably 4 □Unknown
of Vital Records, Physician: The law requires to this certificate has been signeral director, page 2 should be	Completed						24a. Was		utopsy findings available completion of cause of
The I	l P						perfo 1 ☐ Yes	ormed? death? 2. No 1 ☐ Ye	
f Vital F ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	lospital:			1	e of Death (Check only	one)	
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Sing After fune	to	1- Natural 5 ☐ Pending	(Month, Day	Year) In	jury M	Injury at Work?		now injury occurred	
Division or Attending effer death. Director: After	flca	3 Suicide 6 Could not be	28e. Place of Injur	ry - At home, far	m, street, factory, of	fice	28f. Location (Street and Number or F	Rural Route Number,
S effe	Certification:	4 Homicide	building, elc.	(Зреспу)			City or To	wn, State)	
Division or To the Hospital or Attending Ph Within 24 hours effer death. To the Funeral Director: Affer th ormpletely filled in by the funeral	edical	(Check only one)	ner: On the basis of e	examination and	or investigation, in	my opinion, de	nd place, and due to the ath occurred at the time,	date and place, and du	e to the cause(s)
Withir To th	ž	29b. Signature and title of certifier	\wedge		29c. L	icense number		29d. Date signed (Mon	ith, Day, Year)
id		• ON V	_		R	ES-C	000	Tarvary 14	1,2006
13/1		2 2 5	impleted cause of de	ath (Item 23a) (Type, Print)	4	4 6 1.1	00100	no to
\~~~~	ate	31. Date filed (Month, Day, Year)	32, Registral	r's Signature	3 Wolfe	J7/20	I Dalt	inore, 11	lary land.
Regist			06 Alcon	as die	San Care Contract		000 . + Balt.		

				1 - For State Registrar		Department of Health and M Certificate of Death	-	9006 01099
_		Physici /Medic		1. Decedent's Name (First, Middle, La Nav Nelson	st)		January 1	ay Year 8, 2006 6.05 ρ M
		Examin Funeral		4a. Facility Name (If not institution, gives	-s	4b. City, Town, or Location of Death irthday) If Under 1 Year If Under 24 Hrs. Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	
		Director Mould Manual M		217 - 26 - 0139 Usual Residence of Decedent 10a. State 10b. County		wn or Location	July 28, 19	10d. Inside City Limits
		deeth with the Maryland ms 23a or 28a-f show r.must be notified at	Director	10e. Street and Number	none Perr	10f. Zip Code	10g. C	1 ☐ Yes 3 No
:05 p.m.		ges 1 and 2 should be filed within 72 hours after deeth with the Marylan to Health and Mental Hygiene. If Item 27 is marked other than "natural; or items 23a or 28a-f show or other traumatic event. It is Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Amed Forces? 1 □ Yes 250 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sr. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc.
9:9	21215-0036	within 72 hou iene then "natura the Medical E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation 16	a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Layns Represented	king	Kind of Business/Industry
, 2006	pu	should be filed ind Mental Hygi marked other umatic event.	To Be Co	17. Father's Name (First, Middle, Last	Wiley		ne (First, Middle, Maide ce Blac	en Sumame)
JANUARY 18,	Baltimore, Ma	Z 2 6 8		MCRK A NELSON 20a. Method of Disposition Burial 2 Cremation 3 C 4 Donation 5 Other (Special	20b. Place cernet	3 Rride Lane, Per of Disposition (Name of en, crematory or other place)	Dale 200.	aculand 21236 Location - City or Town, State
JAI	Balt	permit. I Depertm Importer any inju		23a. Part V. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do	22. Name and Address of Facility Events 18800 Har Full Rocco	1 Parkville	of manyland 21234 Approximate Interval Between Onset and Death
	760, 5	Medical Examiner bhysicien and sthe purial-transit	edicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence c. Due to (or as a consequence c. Due to (or as a consequence d.	o of:		
	. Box	that the death certificate led by the attending phy detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 【 No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dear 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
NELSON	rds, P	w requires that the been signed by the should be detache	ě	Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death? 2 No 3 Probably 4 MUnknown
NAN NEI	l Rec	The law ete has b page 2 sh	Completed				24a. Was an autopsy performed?	
N	of Vital	> 0 0	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3 DOA Other: 4 Nursing He	th (Check only one) ome 5 Residence	6 NOther (Specify) HOSPICE
	Division o	To the Hospital or Attending Ph within 24 hours atter deeth. To the Funeral Director: After th completely filled in by the funeral	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	Time of Injury at Work? Injury M 28c. Injury at Work? I Yes 2 No	28d. Describe how inj	and Number or Rural Route Number,
	Div	Hospital or A 14 hours after Funeral Dire tely filled in by		4 Homicide determined	building, etc. (Specify)	ge, death occurred at the time, date and place,	City or Town, Sta	ite)
4		To the Hos within 24 ho To the Fun completely	Medical	(Check only 2 Medical Exa	niner: On the basis of examination a and manner stated.	and/or investigation, in my opinion, death occur	rred at the time, date a	and place, and due to the cause(s) Date signed (Month, Day, Year)
		10		30. Name and address of person who DR. TARIQ MAHMO 31. Date filed (Month, Day, Year)		VALLEY RD. TIMONIUM	, MD 21093	1111100
		Sta Regist		IAN 2 0 2006	Se. riogistial s digitature	bod .		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4c. County of Death Facility Name (If not institution Town, or Location of Death Examiner 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F J2-44-0272 Usuat Residence of Decedent Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits oriant: If Item 27 is marked other then "natural", or Itame 23a or 28a-f show Injury or other treumatic event, the Madical Examinar must be notified at 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes WNo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 Maryland 21215-0036 ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
tita_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other then "na any Injury or other treumatic event, the Media once. condrary (0-12) Coltege (1-4or 5+) Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore. . Method of Disposition

Disposition

Comparison 20b Place of Disposition 20c. Location - City or Town, State 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funerat Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebro Vascu **Physician** /Medical Due to (or as a consequence of): Examiner unknown Diabetes Socialisally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. tf yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Kenal 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 25. Was case reterred to medicat examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certilic completely filled in by the funeral director,

Medical Certification: To Be

27. Manner of Death 1. Naturat 2 Accident 3 Suicide 4 - Homicide

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

5 Pending

investigation

6 ☐ Could not be

SO MD

838 tospice

28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify)

no completed cause of death (Item 23a) (Type, Print)

29c. License number

1)24170

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

31. Date filed (Month, Day, Year)

3

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month 7, **Physician** 4:45 PM January 2006 J. O'Connor Thomas /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner Annapolis Nursing and Rehabilitation Center Anne Arundel Annapolis 9. Birthplace (State or Foreign Country)

New York If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept.21,1932 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** 1**⋤**M 2□ F Hours 73 376-30-8560 Director Usual Residence of Decedent 10d. Inside City Limits Marylend 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1/X Yes 2 No Jacksonville Director Duva1 Florida the 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number with United States 32218 15291 Parete Circle East death v Funerai 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any Injury or other traumetic event, the Medical Examina. 1 X Yes 2 □ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Korean White 1 Yes 2 No Specify: Specify: Baltimore, Maryland 21215-0020 2 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Shipping/Receiving Clerk Repair Business 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Josephine McNamara Thomas O'Connor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15291 Parete Circle East, Jacksonville, FL 32218 Terry Montgomery 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State April 1,2006 Corinth, New York Corinth Rural Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Densmore Funeral Home re of Fundral Service Licensee 7 Sherman Ave., Corinth, New York 12822 M01113 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ARTERIOSCIENOMO CONDIOUASCUIAN DISEAS Examiner Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours effer deeth.

To the Funeral Diractor: After this certificate hes been signed by the ettending physicien and buniel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760. ettending physicien for use es the bune Physician/Medical Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of deeth? signed by the e Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 3 □ Probabty 4 □ Unknown 1 ☐ Yes 2 ☐ No Division of Vital Records. δ 24b. Were autopsy findings available prior to icete hes been sign, page 2 should b 24a. Was an autopsy performed? Be Completed completion of cause of death? 1□ Yes 2⊡No 1 ☐ Yes 2 ☐ No director, 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28c. Injury at Work? 28d. Describe how injury occurred funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 I Homicide filled in 1 Critifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edicai 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 101852 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Queensburg Rd Hyattsoffells 2018 100 MD 4203 AUI 32 Registrar's Signature 31. Dete filed (Month, Day, Year) State JAN 2 0 Registrar

				State of		epartment of h			•	0:100
				1 - State Registrer		Certificate of	Death	Re	g. No. UUb	01102
		Physici	àn	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	1	/Medic	al	Frenzella McLeod	Pete		- Lacation of Dooth	l	11 210	
U	1.	Examin	er	4a. Facility Name (If not institution, give street and number	. ,	1 Rose	or Location of Death		Baltin	nore
		Funeral			to Significal Age (In vrs. last birti	hday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		thplace (State or Foreign ountry)
	26	Director		428-76-9604 1□ M 25 F	66	Yrs. Months Days	Hours Min.	Month, Day, March 1	1,1939 Mis	ssissippi
		pur »		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
		death with the Maryland ms 23a or 28a-f show rman be notified at	o	Maryland Baltimore		timore				1 ☐ Yes 2 X No
		r 28a	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What C	ountry?
		th with	ai D	151 Tameron Place		21237			United St	cates
		ems erms	Iner	Armed Ford	dent Ever in U.S. ces?	13. Was Decedent of	Hispanic Origin? (Spectan, Mexican, Puerto R	ofy Yes or No- lican, etc.)	14. Race - Am Black, Whi	
E S	36	s afte	by Funeral	1 Never Married 2 Married 1 Yes, 2 If Yes, Give 3 Widowed 4 Divorced Year or Dat	3	1 ☐ Yes 2 ☐ X No	Specify:			Black
17	9	within 72 hours after ene. then "netural", or ite	edt	15. Decedent's Education		Decedent's Usual Occu	pation	1	6b. Kind of Business	s/Industry
X	215	hin 72	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	4or 5+)	(Give kind of work done life. DO NOT use retire	during most of workingd)	9		,
70	2	gient gient er th	Completed	12		Assemble	r		Auto Manui	acturer
PROSECULA PETER	Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is merked other then "netural; or items 23a or 28a-f show amy injury or other traumatic event, the Madical Examinat must be notified at ance.	To Be	Joe McLeod			18. Mother's Name Ruby Br	(First, Middle, M OWN	faiden Sumame)	
E.	aryl	shoul and Me s marl	۲	19a. Informant's Name/Relationship (Type, Print) Gr		Mailing Address (Stree	t and Number or Rural	Route Number,		
		and 2 ealth a n 27 is		Demeaterus Shauhn Johnson		1 S. Molino		The state of the s	na, Califo	ornia 91101
	Baltimore,	ges 1 t of Hi ff iter or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from S	nate	Disposition (Name of y, crematory or other pla		4	20c. Location - City or	
	Iţim	rt. Partmen		4 Donation 5 Other (Specify)	Inglew	ood Park Cemet		and the Control of th		Lifornia
	Ba	Depa impo any i		21. Signature of Funeral Service Licensee	M01113		ess of Facility Simps hester Blvd.	-	-	
	-			23a. Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death. Do n	not enter the mode of dy	ing, such as cardiac or	respiratory arre	st,	Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition	e Respira	tory Distr	ess Sun	drom	e	Onset and Death
		/Medical Examiner		resulting in death) Due to (c	or as a consequence of	of):	J			
			-	Sequentially list conditions, if any, leading to immediate	tenitis	of):				
		uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
.)	o,	te be executed ysicien and ie burial-transit		requilibration in allegable lines	or as a consequence of	of):				
00	3760	or Attanding Physician: The law requires that the death certificate be executed titler death. Director: After this certificate has been signed by the attending physicien and in by the funeral director, page 2 should be detached for use as the burial-transit	licai	d						
7	x 68	entific ding p	/Mec	IF FEMALE:						
	Вох	attend for us	ian	in the past 12 menths?	come of pregnancy rth 2 Fetal death ant at time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	су		23d. Date of de Month	elivery . Day Year
	0	that the death certificate ed by the attending phys detached for use as the	Completed by Physician/Medi	1 Yes 2 No 4 Pregna 9 Unknown 9 Unknow		3 Office (specify)				
	<u>ب</u>	es that igned b	Y P	Part II. Other significant conditions contributing to dea	ath but not resulting in	the underlying cause g	iven in Part I.	23e. Did tob	acco use contribute t	to the cause of death?
	rds	law requires as been sign 2 should be	ed b	Renal Failure				V Ye	s 2 □ No 3 □ P	robably 4 □Unknown
	ဝ၁	law requas been 2 shoul	plet	Pancytopenia				24a. Was an		utopsy findings available completion of cause of
	Œ	The la	Con	Obesitu				perform	ned? death?	s 2010
	Vita	ician: Th certificate ector. pag	Be	25. Was case referred edical examiner? Hospital:		10	26. Place of Death	(Check only one	9)	
	ō	Phys r this rat dir	- T	1 Yes 2 No 10351181. In 27. Mannerof Death 28a. Date of	npatient 2 ER/Ou	ipatient 3 DOA			nce 6 Other (Spewinjury occurred	ecify)
	on	tending Physician: leath. tor: After this certific the funeral director.	tion	1√Natural 5 Pending (Month 2 Accident investigation	h, Day Year) Ir	njury Wo	ork? □Yes 2□No	od. Describe 110	W Injury occurred	
	Division of Vital Records, P.O.	al or Attendi s after death. i Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of	of Injury - At home, fa	rm, street, factory, office	2	8f. Location (Str	reet and Number or F	Tural Route Number,
	Ö	ital or rs afte ai Dir	Cert	Dulldin	ng, etc. (Specify)			City or Town	, State)	
		To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the la 2 Medical Examiner: On the ba and mann	isis of examination an	e, death occurred at the t d/or investigation, in my	time, date and place, a opinion, death occurre	nd due to the ca d at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
		To the within 2 To the complet	Me	29b. Signature and title of certifier			nse number	29	d. Date signed (Mon	ith, Day, Year)
				1. Bry Xhuhlanthis	5	1-1	18988		1/11/06	
				30. Na and address of person who completed cause						
				31. Date filed (Month, Day, Year) 32. Re	9 00 egistrar's Signature	Mi Sylva	P Drive Bo	Hinter	MD:	111 37
		St Regist	ate rar		W-	frank i				
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DHMH 17 Rev 1/2001

ORIGINAL

	1	State of Maryland / Dep	partment of Health and Nertificate of Death	Mental Hygier	2000	01103
- 第	_	I. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
Physicia /Medica	al	Peter Ray Proctor		Jan 15,200		12:30 A M
Examine		a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	amaa! =
		15800 Letcher Road	Brandywine v) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince Ge	
Funeral	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 577 14 4763 2 F 92'rs.	Months Days Hours Min.	(Month, Day, Ye	ar) Scoun 913 Mary	lace (State or Foreign try) 1and
Director	-	Jsual Residence of Decedent		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
yland		10a. State 10b. County 10c. City, Town or	Location		1	0d. Inside City Limits
e Mai	ctor		randywine		Chinas - Chin : C	1 Yes 2 No
or 28	Directo	10e. Street and Number	10f. Zip Code 20613		Citizen of What Coun	
ath w	ral	15800 Letcher Road 11 Marital Status 12. Was Decedent Ever in U.S. 13			14. Race - Americ	
Ind X IX 13-0030 be filed within 72 hours after death with the Maryland at bygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Exeminar must be notified.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Mo If Yes, Give 11 Yes 7 Dates:	Was Decedent of Hispanic Origin? (Sill Yes, specify Cuban, Mexican, Puert □ Yes 2□ No Specify: XX	o Rican, etc.)	Black White, Nati Specify:	ve American
d within 72 hours af giene. or than "natural", or it to Michical Exem	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of wor b. DO NOT use retired)	king 16b	. Kind of Business/Inc	dustry
Z I Z d with giene.	mo		ck Driver		Concrete	
be filed hall Hygin of other	Bec	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	den Sumame)	
should be ind Mental in marked of umatic eve	٦٥ ا	William Joseph Proctor		<u>Linkins</u>	ity or Tour State 7:-	Code) 20725
Maryland od 2 should be file lih and Mental H) 27 is marked oth		, , ,	alling Address (<i>Street and Number or Ru</i>)1 01d Alexandria I			
2 a a E E		`			Location - City or To	
BAIKIMOFE, permit. Pages 1 ar Department of Hea Important: If item: eny lnjury or othe	111	1 △Burial 2 □ Cremation 3 □ Hemoval from State	rematory or other place) Jan. ction Cemetery 200		linton, Ma	ryland
IIIIII artmei ortant Injury		4 □Donation 5 □Other (Specify) Resurred	22. Name and Address of Facility Lee			
Department of the control of the con		Mila D. Dibbs morsey	Alexandria Ferry I	coad. Clin	ton. MD 20	735
		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiad	or respiratory arrest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death) a. RENAL FAIL Due to (or as a consequence of):	URE			9 YEARS
Examiner		HINDER TENSIS		EROT1	c 4	to YEARS
D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	CARDIOVAS	CULAR	DISEASE	/
. Box 68760, death certificate be executed to attending physician and for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events c				
I / 60, Ite be ext lysician and ne burials	ical Ex	255 to (5, 45 4 55 155 455 165 51).				
687 tificate ig physi as the l		d				
BOX 61 eath certific attending p	N/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of deliver	•
death death	Physician/Med	in the past 12 months? 1 Yes 2 No	5 Other (specify)		Month	Day Year
that the de hed by the s	Phys	9 Unknown	o underhing gaves awas in Dest I	23a Did tohan	co use contribute to t	he cause of death?
cords, F w requires tha been signed should be def	þ	Part II. Dther significant conditions contributing to death but not resulting in the	POSTATE		2 No 3 Prol	Δ.
Re la he la he has la has	Completed			24a. Was an autopsy performed	24b. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of
	0	25. Was case referred to medical		ath (Check only one)		
on of Vital ding Physician: h. After this certifications of the physician	To B	A	and the second second second		e 6 Other (Speci	fy)
E e e		27. Manner ol Death 1 Matural 5 ☐ Pending 28a. Date ol fnjury (Month, Day Year) Inju Inju	ry Work?	28d. Describe how	injury occurred	
Vision Attending or death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm	M 1 Yes 2 No	281. Location (Street	et and Number or Run	al Route Number.
DIVISION tal or Attending s after death. al Director: After	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, S	State)	
DIVISION To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, control on the basis of examination and/control on the basis of examination and control on the basis of examination and	leath occurred at the time, date and place or investigation, in my opinion, death occ	urred at the time, date	and place, and due t	o the cause(s)
To th withir To th comp	Me	29b. Signature 15th title of certifier	29c. License numb	16 17	Date signed (Month,	Day, Year) NUARY
		29b. Signature of title of certifier Pariela lynhai	D 800 /16/	, XO	20	06
110		30. Name and address of person who completed cause of death (Item 23a) (Ty	D # 750 C	SUHA	1	20025
1		9/31 PISCATAWAY ROAS 31. Date filed (Month, Day, Year) 32. Registrar's Signature	D # 750 C	LINTOR	mo a	20/33
St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 2 0 2006 32. Registrar's Signature	soul!			

			1 _ State	Department of Health and in Certificate of Death	2000 01104
	An and a second		Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No. 2. Date of Death 3. Time of Death
	Physici	an	C = 22 - 1 - 2 - 1 - 1		Month Day Year
T . š	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	JAN 11 2000 - 10 1
	Examin	er	0 0	0 11	ALC COUNTY OF DEATH
	Funeral	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last bir	thday) If Under 1 Year If Under 24 Hrs	8. Date of Birth 9. Birthplace (State or Foreign
7	Director		100 11 0001	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Pay Year) Pennsylvania 9. Birthplace (State or Foreign Country) Pennsylvania
	of Mrs.		Usual Residence of Decedent		
	how		10a. State 10b. County 10c. City, Town	n or Location	10d. Inside City Limits
	Ba-fa	cto	Maryland Anne Arundel Seve	erna Park	1 ☐ Yes 2 [X No
	vith th	Director	43 McKinsey Road Apt. 105	10f. Zip Code 21146	10g. Citizen of What Country?
	a 23	rai			United States
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depirtment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23s or 28a-f show many njury or other traumatic event, the Madical Examinar must be notified at ances.	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 △ Yes 2 □ No WWII 11. Was Decedent Ever in U.S. Armed Forces? 1 △ Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
5	72 h	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work	16b. Kind of Business/Industry
7	Athin De.	npi	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	
2	tygier ther th		14	Secretary of Transp	
Maryland 21215-0036	uld be fi Aental H rked ot tic ever	To Be	Steve Pulakos		ne (First, Middle, Maiden Sumame) ine Bolger
Mary	12 should and Men 1s marke raumatic				ural Route Number, City or Town, State, Zip Code)
	1 and Health Iom 27 other to		20a Mathod of Disposition 20b Place of	Disposition (Name of	Severna Park, MD 21146 Date 20c. Location - City or Town, State
altimore,	Pages nent of I int: If its iry or o		1 ♣ Burial 2 □ Cremation 3 ♣ Removal from State Calvar	ry, crematory or other place) ry Cemetery Jan.	16,2006 Erie, Pennsylvania
Balti	permit. Departm Importa any nju		21. Si III Funer I Service Licensee		irton Funeral Home
	005 e d	1	M01113	<u>-</u>	Erie, Pennsylvania 16505
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do r shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a DNEW MO)	1	Approximate Interval Between Onset and Death
	/Medical		resulting in death) Due to (or as a consequence		A Takys
	Examiner	_		novacolomy	June 10 days
T	ad sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	of):	Marie
1	and I-tran	Examin	that initiated events resulting in death) Last C. Due to (or as a consequence of	ora-x	I laays
8760,	cate be executed physician and the burial-transit			tures // 1/	agree 17 days
387	ficate be executed physician and s the burial-transit	dicai	d. TIB ITAL		17 Mays
×	ding se as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	3 □Ectopic pregnancy	
Вох	The law requires that the death certificate has been signed by the attending lagge 2 should be detached for use as	Physician/Me	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
o.	the d y the iched	ysi	1 Yes 2 No 9 Unknown 9 Unknown	3 dillor (specify)	
T	that ned b	y P	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Division of Vital Records, P.	quire;	d by	normal pressure hydroc	cohalus	1 Yes 2 No 3 Probably 4 Unknown
000	w rec	iete		/-	24a. Was an 24b. Were autopsy findings available
æ	he law e has age 2:	Completed			24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
ā	ician: Th certificete rector, pag	Ö	25. Was case referred to medical	GC Blace of Dec	1 Yes 2 No 1 Yes 2 No No No No No No No
5	ysicia s cer direct	To B	examiner? 1 Yes 2 No Hospital: I Impatient 2 ER/Ou	Other	ome 5 ☐ Residence 6 ☐ Other (Specify)
5	g Ph er thi	L.	27. Manner of Death 28a. Date of Injury 28b. T	Time of 28c. Injury at	28d. Describe how injury occurred
<u>o</u>	ndin ath. r: Aft e fun	atio	1 □Nakural 5 □ Pending (Month, Day Year) II 2 □ Accident investigation □ 2 C 24 2005 5:	njury Work? 20 PM 1 □ Yes 2 No	FALL
N N	er de er de recto by th	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specily)	rm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Jown, State) SUATISEC & SEVERINE PORK
ā	rs aft	Certification:	HOME		Severna Park, MD
	To the Hospital or Attending Physician: The within 24 hours after dauth. To the Funeral Director: After this certificete his completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 2 Medical Exeminer: On the basis of examination and manager stated.	o, death occurred at the time, date and place d/or investigation, in my opinion, death occu	and due to the cause(s) and manner as stated
	ro the vithin or the comple	Mec	and manner stated. 29b. Signature and title of/certifier	29c. License number	29d. Date signed (Month, Day, Year)
	. > = 0		Man tonnon 110	M16772	
	.0		30. Name and address of person who completed cause of death (Item 23a) (JAN 11, 2006
	[U			ayette Street. Baltin	1012 MD 21201
400	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Last 1	1010 1011) 61101
200	Registr		JAN 2 0 2006 A A		

			For Stata Registrar	State o	of Marylan		artment <i>tificate</i>			nd M		giene ()	06	01105
· /遊	Physicia /Medic		1. Decedent's Name (First, Middle Lenwood K. Pe								2. Date of Dea Januar		2 <i>0</i> 06	3. Time of Death 1748 M
	Examin		4a. Facility Name (If not institution Anne Arundel			r			Location of	Death		4c. Count		undel
	Funeral Director		5. Social Security Number 217–18–6913	6. Sex 1 M 2 ☐ F	7. Age (In yrs. I		If Under		If Under 2 Hours	Min.	8. Date of Birt (Month, Da Sept 2		9 Birth	nplace (State or Foreign untry) aryland
91.	ryland thow		Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo	cation						,	10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show r must be notified at	Directo	Maryland Anne 10e. Street and Number	Arundel	A	nnapo	lis 10f.Zip	Code				10g. Citizen of	What Co	1 TyYes 2 No untry?
	ath with 23a o	ral Di	1226 Madison	St.				214					SA	
	of within 72 hours after death with the Marylan jiene. Jiene. Than "natural", or liems 23a or 28a-f show the Modical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married	ed 1 X Yes	2 🗆 No		Vas Decede fYes, speci l□Yes 2		spanic Orig n, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No- Rican, etc.)		ce - Americk, White	
5	72 hou	Completed	15. Decedent (Specify only highes			16a. Deced	dent's Usual kind of world DO NOT use	l Occupa k done d	tion uring most	of workin	ng .	16b. Kind of 8		00 1 10 mm - 1 10 mm - 1
7	within iene. r then	отрі	Elementary/Secondary (0-12) 10th	College (1-4or 5+)		ical					Anne		Center
ana	Hygent,	Be C	17. Father's Name (First, Middle,	Last)		l						Maiden Suma	me)	
5		၉	Charles Perge		•	19h Mailir	Address	(Street a			Richar Rowa Mumbo	dson or, City or Town	Stato 7	in Code)
Z	2 # 2 E		Laretta S. Pe		(Wife)		-							. ,
ore,	Pages 1 and the south of the so		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation	3 □Removal from	State	lace of Dispo emetery, cren	natory or oth	her place			ate	20c. Location		
aitimol			4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service I		Ma	rylan				-17				le, Md.
ŭ	permit. Departr Import eny inj		Lavry S.		110098	7 8	m. Re 21 We	ese	& S St.	ons Anna	Mortu apolis	ary, 1	214	01
			23a. Part1. Enter the J sease, or shock, or heart f illure. List	complications that only one cause on	_			-	-			rest,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a	(or as a consequ	astro	in te	stin	I E	3le	29	· · · · · · · · · · · · · · · · · · ·		
	Examiner	i i	Sequentially list conditions	b	(0) 43 4 0011364									
ę.	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequ	uence of):								
Ď.	certificate be executed adding physician and use as the burial-transit	ıl Exar	that initiated events resulting in death) Last	c. Due to	(or as a consequ	uence of):								
09/99	fficate t g physic as the b	edical	N	d										
O. BOX	death e atter d for u	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live I	itcome of pregna birth 2 Petal nant at time of de lown	death 3	Ectopic pre Other (spe						ate of deli- onth	very Day Year
ds, r	requires that the een signed by th nould be detache	d by Ph	Part II. Other significant condition		leath but not resu	ulting in the u	nderlying ca	iuse give	n in Part I.		23e. Did to			the cause of death?
Records	law asb 2 st	Completed	Aportic St	enosis							24a. Was autop	an 24b.	Were aut	topsy findings available ompletion of cause of
_	ysician: The law is certificate has b director, page 2 s		25. Was case referred to medical								1 Yes	med? 2 No	death?	2 No
r vital	Physician: this certific	o Be	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatien	t 3 🗆 DO/	A Othe	c		(Check only o	<i>ne)</i> lence 6 ⊟Oti	ner (Spec	ıfy)
5 5	ing Ph	ion: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	9	of Injury oth, Day Year)	28b. Time of Injury	M 28	Bc. Injury Work			8d. Describe h	ow injury occu	rred	
DIVISION	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determi	not be 28e. Place	e of Injury - At ho ing, etc. <i>(Specif</i>)	ome, farm, str			′es 2 □ N		8f. Location (S City or Ton		ber or Rui	ral Route Number,
	Hospita 24 hours Funeral etely fille	Medical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the Examiner: On the b and man	e best of my kno basis of examinationer stated.	wledge, death tion and/or inv	occurred a restigation,	it the tim in my op	e, date and inion, death	place, a	nd due to the o	cause(s) and m date and place,	anner as and due	stated. to the cause(s)
	To the within To the Complex c	Me	29b. Signature and title of confiner					License				29d. Date signe	ed (Month	. Dey, Year)
	111	<	104			_>			285			1/10	100	>
4	400		30. Name and address of person of the supplemental address o	way MS	unde C	1 23a) (Type,	mdel	m	9 C.	tv	Anna	polis 1	CN	21401
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 0 2	006	Registrar's Signa	ture	المثا							

			For State Registrar	State of Marylar	id / Dep <i>Ce</i>	artment of rtificate of	Health and Death		giene 006	01106
8	Physici		Decedent's Name (First, Middle, Last, Patsy Ruth Peak)				2. Date of De Month	ath Day Year	
	/Medic Examin		4a. Facility Name (If not institution, give FRANKIN SQLA 5. Social Security Number 6. Se 242 56 8358 15 Usual Residence of Decedent 10a. State 10b. County	RE HOSPIT, XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	last birthday, Yrs.	Ros If Under 1 Yea Months Days		th B. Date of Birl	4c. County of Dea	
	Maryla I-f sho	tor	Maryland Baltimor		Essex					1 ☐ Yes 2 No
	h with the	al Director	10e. Street and Number 65 Rockywood Lane			10f. Zip Code 21 2	221		10g. Citizen of What C	Country?
036	J within 72 hours after death with the Maryland jiene. I then "netural", or Items 23s or 28s-f show The Majical Evainmer mush by mullied al	by Funeral	11. Marital Status 1 Never Married 2 Marned 3 XWidowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	.S. 13.	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 No	Hispanic Origin? (Sban, Mexican, Pue ban Specify:	Specify Yes or No to Rican, etc.)	14. Race - Am Black, Wh Specify: Wh	ite, etc.
21215-0036	within 72 ane. then "nel	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	(Give	edent's Usual Occi e kind of work don DO NOT use retir	e during most of wo ed)	orking	16b. Kind of Business Aerospace	s/Industry
land 2	be filled htal Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last) Lytle W. Darnell					me (First, Middle, e Wehry	, Maiden Surname)	
Maryland	od 2 shouth and N	_	19a. Informant's Name/Relationship (Ty Diana Hensler (Dau		1		et and Number or A d. Baltir		er, City or Town, State, 21220	Zip Code)
Baltimore,	Pages 1 ar nent of Hea ant: if Item ary or otha		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	cemetery, cre	osition (Name of imatory or other pl 11 Mem. C		Date 21/2006	20c. Location - City o Baltimore,	
Balti	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Licens	rkouske	E T	2. Name and Add Bruzdzins 407 Old	kı Funera	al Home I Avenue Es	P.A. ssex, Md. 2	1221
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complete shock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)	Due to (or as a consec	UM T	sury um	DIA			Approximate Interval Between Onset and Death MUNICS
8760,	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect.	uence of):	IC CARDI		015+2	3 G	
P.O. Box 6	The law requires that the death certific sie has been signed by the atlending p page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	33c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	Il death 3	□Ectopic pregnan □ Other (specify)	су		23d. Date of de Month	elivery Day Year
rds, P	quires that n signed b uld be deta	þ	Part II. Other significant conditions co				iven in Part I.	23e. Did to	obacco use contribute s	to the cause of death?
Division of Vital Records,		Completed	CIMMINE USSIMUL	THE PHIMON	my D	136456		24a. Was autor perfo 1 \(\text{Yes} \)	osy prior to ormed? death?	utopsy findings available completion of cause of
Vita	Physician: this certific ral director.	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3□ DOA O		ath Check only o	one. dence 6 ⊟Other <i>(Spe</i>	ocifu)
ion of	nding Phy ath. r: After thi e funeral d	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28c. Inj	ury at ork?		how injury occurred	Sony
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, st	reet, factory, office	3	28f. Location (S City or Tox	Street and Number or F wn, State)	lural Route Number,
	Hospi 24 hour Funer stely fill	ledical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knoner: On the basis of examination and manner stated.	owledge, dea ation and/or in	th occurred at the ovestigation, in my	time, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the vithin To the comple	Me	29b. Signature and title of certifier MMMM M				nse number		29d. Date signed (Mon	
10			30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type	Print)		une so	mugno	71237
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 0	32. Registrar's Signi		South o			.,	

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				State of Mary				•	3	•
			1 - For State Registrer	State of Mary	•	tificate of		antai mygie Reg.	ZUUb	01107
			Decedent's Name (First, Middle, Last) 2. Date of Death						NO.	3. Time of Death
	Physici /Medi		Dora Cat	herine F	Parsons			ANUAR	Day 19 20	5.20AM
	Examin	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death						4c. County of De	
			Of the state of th							ARUNDEL
	Funeral Director									9. Birthplace (State or Foreign Country) NC
	show		Usual Residence of Decedent	140	0: T					T
		'n	Maryland Anne A		: City, Town or Lo		timore			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
•	289-	rect	Maryland Anne Arundel Baltimore 1 □ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?							
	23e of	by Funeral Director	7800 Shellbourne Road 21226 USA							
	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show digal Examiner must be notified at	ner	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. \	Was Decedent of Hispanic Origin? (Specify Yes or No- f Yes, specify Cuban, Mexican, Puerto Rican, etc.)		ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.	
36		by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed 4 ☐ Divorced	1 Tes 2 No If Yes, Give	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No Specify:			_{Specify:} White
21215-0036	eture lcal E	ted	15. Decedent's E	ducation	16a. Deced	ent's Usual Occup	pation	166	b. Kind of Busines	ss/Industry
21	permit. Pages 1 and 2 should be lited within 72 hours after death with the Marylar Department of Health and Mentral Hygione. Importent: If then 271s marked other then "neturel; or Items 23e or 28e-f show any injury or other treumetic event, the Nedical Evanimer must be notified at once.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			(Give kind of work done during most of working life. DO NOT use retired)			Mostinghouse	
72			8 17. Father's Name (First, Middle, Last)			Inspector 18. Mother's Name (First, Middle, Maid			Westinghouse	
and		To Be				Lela	·			
Maryland		-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							, Zip Code)
Σ,			Martha K. Payton (daughter) 7800 Shellbourne Road, Baltimore, MD 21226							
Jore	tiof H If ite		20a. Method of Disposition 20b. Place of Disposition (Name of commetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State							
Baltimore,	oartmen cortent: injury		*4 Donation \$ Other (Specify) Metro Crematory Inc 2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee							
B	Depa Impo any i		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122							
	103		23a. Part1. Enter the disease, or confications that cause the deam not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between							Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition resulting in death) Onset and Onset and						Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of):					
		Je.	Sequentially list conditions, if any, leading to immediate	b. — Oue to (or as a consequence of):						
	nd nd transit	Examiner	Sequentially list conditions, it arry, leading to manufact cause. Enter Underlying Cause (Disease or injury that initiated events	c.						
760,	ding physician and use as the burial-transit		resulting in death) Last	Due to (or as a consequence of):						
687	attending physical for use as the t	d								
Вох	anding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy					23d. Date of delivery	
. 7	2 9 8	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 Pregnant at time of death 5 Other (specify)				Month Day Year		
P.O.	± ≥ ∞	by Physician/Medi	9 Unknown		stributing to death but not resulting in the un-		nderhing cause gwen in Part I		23e. Did tobacco use contribute to the cause of de	
Records,	w requires ina s been signed t should be det	d by	, and an activity in a control of the control of th							
CO	s beer	lete						24a. Was an 24b. Were autopsy findings available		
Re	nysicien: The law his certificate has t I director, page 2 s	Completed			autopsy performed′ 1 □ Yes 2 15M					
of Vital	entifica actor, I	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)						
of \	fin. After this certification funeral director, i	P	1 ☐ Yes 2 No 27. Manper of Death	Hospital: 1 Inpatient 2 ER/Outp 28a. Date of Injury 28b. Tin				ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred		pecify)
uo .	After fune	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea n	(r) Injury			250. Baseria in injury december		
Division	after death. Director: A	Certification:	3 Suicide 6 Could not be determined	280 Place of Injury. At home form street feeters effice.					and Number or Rural Route Number,	
	urs after rel Direc									
	to the nospite of Attenuing within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	To the	Mec	29b. Signature and time of certifier			29c. License number 29d. D			Date signed (Month, Day, Year)	
) '	+		150000	70	mis	100	f5149	A	NUARY	F 2006
	10		30. Name and address of person who	completed cause of death		Print)	CIRNI	BURNI	e in	1 200G
			31. Date filed (Month, Day Year)	32. Registrar's S		ANITE	YUEN	1700019	1100	2 - 10 61
	Sta Registi		JAN 2 0 2	nns A	H A	A B				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 21:15 M January 11, 2006 Packard Neal /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air
If Under 1 Year If Under 24 Hrs. Upper Chesapeake Medical Center Harford 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F Hours 70 224-44-3114 Maine Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28e-f ehor the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Harford Fallston 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 211 Reckord Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White ges 1 and 2 should be filed within 72 hours t of Health and Mental Hygiene. If Item 27 is marked other than "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Space Research Engineering Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earl Packard, Sr. Lillian Catherina Woodbury Charles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 Reckord Road, Fallston, Maryland 21047 Eleanor Packard/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of I 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If eny injury or once. Stabler's Church Cem. 1-14-2006 Parkton , Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service accensee ^{22. Name and Address of Facility}
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate
Interval Between
Onset and Death 23a. Part1. Enter the disease, or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on yone pause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): CHRONIC MONO MYELOGENOUS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): ierel Director: Afler this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the buria by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HEART FAILURE O ONGESTIVE 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 2 PNo 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ZMo 1 I npatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Beath 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aff To the Eunerel Di comple ely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b Signature and title of certified 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

ackard John # 03662

f person who completed cause of death (Item 23a) (T pe. Print) 31,2

32. Registrar's Signature

AUSTON MA

Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** essie 8: 20 PM 2006 0 0 /Medical 4a. Facility Name (If not institution, give street and numb 4c. County of Death 4b. City, Town, or Location of Death Examiner Long View Nursing Home Manchester Carroll 8. Date of Birth (Month, Day, Yeer) Aug. 27,1919 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Funeral Months 1 ☐ M 2 🗓 (F 86 Yrs. Director 166-12-7377 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show other cust be notified at Baltimore 1 ☐ Yes 2 No Funeral Director Carrol Upperco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15227 Old Hanover Road 21155 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify. Specify: the Medical Exa \$ 3 X Widowed 4 □ Divorced naturel White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Seamstress Jos. A. Bank Clothier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) æ is marked o Mental Pages 1 and 2 should Lyda Plummer Ora Lee Sebastian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 is any injury or other tree once. Daughter 15227 Old Hanover Road, Upperco, MD 21155 Barbara Jean Pearson Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Gard | 1/13/06 Finksburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road fine Eline Funeral Home Reisterstown, MD 21136 Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimer Physician /Medical Due to (or as a consequence of): Examiner CV Sequentially list conditions, any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) Ó 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> Records. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has the all director, page 2 and director, page 3 and director, director autopsy performed? 2 No 1□ Yes 2□No 1 Yes of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) oel or Attu.

Jurs after death.

Vel Director: After this Lucy the funeral dir Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 XNo 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide To the Hospitel o within 24 hours aff To the Funerel Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 51705 5000 Columbs. 30. Name and address of person who comed cause of death (Item 23a) (Type, Print) restrainstes, mp 21157 M. PANSURIYA 349 IN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 Registrar 0

_			1 - For State Registrar		ryland / Depa <i>Ce</i>	artment of I			giene 0 0	6 01110
	Physici		1. Decedent's Name (First, Middle, Last, Carol Ann Rapisar					2. Date of Dea Month January	Day	Year 12:45 pm
	/Medic Examir		4a. Facility Name (If not institution, give				or Location of Death	-	4c. County of	of Death
	Funeral Director		5. Social Security Number 6. Security Number 6. Security Number 6. Security Number 10		(In yrs. last birthday) Yrs.	Bel Ai If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birt. (Month, Day Dec. 2	h	9. Birthplace (State or Foreign Country) Maryland
	D		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation		Dec. 2.	1, 1,	10d. Inside City Limits
	the Mar 28a-f sl	Director	Md. Harfor	d	Bel A	ir 10f. Zip Code			10g. Citizen of W	1¾ Yes 2 □ No
	3e or			Dood		,	1014		U.S.A.	nat Country?
9036	72 hours after death with the Maryland "neturel", or Items 23e or 28a-f show officel Examinat must be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Endemed Forces? 1 ☐ Yes 2 ☑ Note of Yes, Give Year or Dates:			Hispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race Black	- American Indian, K, White, etc. white
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "netun eny injury or other treumatic event, Ite Madical once.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+	(Give	DO NOT use retire	during most of worl	king	16b. Kind of Bus	
9	filled Hygi other		17. Father's Name (First, Middle, Last)	2	non	emaker	18. Mother's Nam	e (First, Middle.		home
rylan	d Mental d Mental narked natic ev	To Be	William Grimm	2:1			Rose Ta	1bot		
	nd 2 sh alth and 27 Is n r treun		19a. Informant's Name/Relationship (Ty) Gregory Rapisarda	-			and Number or Run			
Baltimore,	Pages 1 a lent of Hea nt: If item ry or othe		20a. Method of Disposition 1 ☐ Fourial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Dispo cemetery, crer Bel Air M	natory or other pla	ce)	Date	20c. Location - C	City or Town, State
Balti	permit. Departm Importa eny inju		21. Signature of Funeral Service License		22 S	. Name and Addre	ess of Facility Funeral	Home of	Bel Air	, Inc.
8760,	Medical Examiner behaviorable by Stephen and burial-transit sthe burial-transit	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	METASTA* Due to (or as a		CANCI				Approximate Interval Between Onset and Death 21 months
P.O. Box 68	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tii 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy	/		23d. Date Mont	,
	w requires that been signed b should be det	by	Part II. Other significant conditions con	tributing to death but	not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did tol		oute to the cause of death?
Division of Vital Records,		Completed						24a. Was a autops perform	ned? de	ere autopsy findings available or to completion of cause of ath? Yes 2 No
of Vita	To the Hospitel or Attending Physicien: Th within 24 hours affect death. To the Funerel Director. After this certificate completely filled in by the funeral director, pag	To Be	1 192 5 2 100		2 ER/Outpation		26. Place of Death er: 4 ☐ Nursing Ho	h <i>Check only on</i> me 5 KReside	e) ence 6 □Other	* * * * * * * * * * * * * * * * * * * *
sion	utending I death. ctor: After y the funer	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day)			y at k? Yes 2 □ No	28d. Describe ho	ow injury occurred	i
N N	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Afte completely filled in by the fune		4 Homicide determined	building, etc.			8	City or Towr	n, State)	or Rural Route Number,
	To the Hospitel within 24 hours a To the Funerel to completely filled	edical	29a. Certifier (Check only one) 1 Certifying Physical Examination	icien: To the best of er: On the basis of e and manner state	my knowledge, death xamination and/or inv d.	occurred at the tin estigation, in my o	ne, date and place, pinion, death occurr	and due to the cared at the time, da	ause(s) and manr ate and place, an	ner as stated. d due to the cause(s)
	To t COM	Σ	29b. Signature and title of certifier	emathlogist/	oncologist	29c. Licens		2	9d. Date signed (Month, Day, Year)
	3		30. Name and address of person who con	mpleted cause of dea	th (Item 23a) (Type: I		1555		01/1//	2006
	1		SEIN AUNG, 2021	B EMMORT	ON ROAD,		212, BEL	AIR M	0 21015	5
	Sta Registra	1.3	JAN 2 0 20	32. Registrar	s Signature	and I				-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death KICHARDSON **Physician** 15 PM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner UPPER AIR CHESAPENKE - Marcad If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 200 F 70.7957 Yrs. Director Usual Residence of Decedent 10b County 10c. City, Town or Location 10a State 10d. Inside City Limits HARFCRI 1 ☐ Yes 2 🗷 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1014 12. Was Decedent Ever in U.S. Armed Forces?/ 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

| Compared to the process of the 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental F Is marked of MATO 1 MEX Mailing Address (Street and Number or Rural Route Number 19a. Informant's Name/Relationship (Type, Print) Important: If item 27 is any injury or other traunonce. ROBERI RICHARDSON, HUSBADD & 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c, Location - City or Town, State 1 ☐ Burial 2 Ø Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee CHAPTEL M01220 HILL, MDZIOSA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Priysician 9 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Michardson, Pegg 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 1 🗌 Yes 1 Inpatient Certification; To 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} \) within 24 hours a

To the Fu eral D

completely filled 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature ar D45390 m.D. 16,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 602 SOUTH ATWOOD ROAD # 200, BEL ASR NO 21014 MYO MIN (M.D.)

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JAN 2 0 2006

Registrar's Signature

06-00425 B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 8 per fh 2851 1-23-06 vt.
State of Maryland? Department of Health and Mental Hygiene CHRISTOPHER RICHARDSON 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death JAN. 2006 ear **Physician** 17, 0730 A M son /Medical 4a. Facility Name (If not institution, give to et and number)
ROUTE31 WEST BOUND OF MEDFORD ROAD 4b. City, Town, or Location of Death 4c. County of Death Examiner WESTMINSTER CARROLL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 2.44-50 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F 217-50-8328 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City_Town or Location in than "natural", or items 23a or 28a-f eho the Medical Examiner must be notified at 1 Yes 2 No Director arro Vew 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21776 . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2XNo Specify Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during life. DONOT use retired) host of working Elementary/Secondary (0-12) Cattege (1-4or 5+) XVY8 marked other Father's Name (First. Middle, Last) Be h and Mental ! ichardson Town, State, 19b. Mailing A Item 27 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition Department of It Important: If Ite eny injury or of once. 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State vice ice 2/133 23a. Part1. Ener the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 2 No 3 Probably 4 □Unknown 1 Tes 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of 2 No Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 64 Other (Specify) AT SCENE Hospital: 1 ☐¥Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Injury 1 Natural 5 Pendino 1 ☐ Yes 2 No IN Vehicular accident investigation 06 0729 2 Accident
3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Ptace of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 \(\overline{\text{M}} \) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies O.C.M.E 17, 2006

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State 31 Registrar

J. LARON LO 31. Dale filed (Month, Day, Year)

32 Registrar's Signature

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edistrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗍 🗍 🕌 1 - For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Marjorie Staley Reid **Physician** January 16, 2006 11:26 A /Medical 4b. City, Town, or Location of Death 4c. County of Death Frederick 4a. Facility Name (If not institution, give street and number) Examiner Frederick Somerford House 8. Date of Birth July 13, 1918 II Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sax 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 🛱 F Yrs Mary land 213-18-8355 **Director** Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at Frederick Frederick Maryland XXYes 2 □ No Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21702 U.S.A. 2100 Whittier Drive death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Æ M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify Specify: White þ 3XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within 7 ai Hygiene. I other then "r Elementary/Secondary (0-12) College (1-4or 5+) Board of Education School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be f nent of Heelth and Mental F int: if item 27 is marked of Mary R. Brown Burton D. Staley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2510 Coach House Way, 3D, Frederick, MD 21702 19a. Informant's Name/Relationship (Type, Print) Susan R. Weddle, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XBurial 2 Cremation 3 Removal from State ö permit. Page Department of Important: if eny Injury or once. Mount Olivet Cemetery Jan. 20, 2006 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligensee Reeney and Basford PA Funeral Home Kirchic M00255 106 East Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** VESCULE disease or condition resulting in death) 0 /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peeu 24a. Was an 24b. Were autopsy lindings available prior to completion of cause of death? has autopsy performed? 2 No 1 Yes Q No 25. Was case referred to medio examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury il or Attending P setter death. I Director: After I 28d. Describe how injury occurred Certification: Natural 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours eft. To the Funeral Dir 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and nanner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 January 16, 2006 and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name 300 West Ninth Street, Frederick, Maryland 21701 Casper/Cline, M.D., 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State JAN 2 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** seel 08:30 AM PARC 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NIA BaltimoRe ICAL enter ALTIMORE B. Date of Birth (Month, Day, Year)

July 23, 1915 Pennsylvania Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Min 1 □ M 2 □ F Months Hours 217-03-9790 90 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Harford Directo Maryland Abinadon 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be tiled within 72 hours after death v Department of Health and Mental Hygiene Importent: If item 27 is marked other than "natural", or items 23a any jury or other treumatic event, the Medical Examiner reserved. 502 Ramblewood Drive 21009 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Aircraft Assembler Aircraft Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DeWitt (nmn) Reel Frances (nmn) Chesney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary M. Waitkus/friend 502 Ramblewood Dr., Apt. 206, Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Grdn. 1-16-06 Bel Air, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Omas 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the direase, or complications that caused the sale. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardicinyopathy Physician Dilated Years /Medical Due to (or as a consequence of): Examiner Bowel 3 Days Ischemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Heart Failure 1 Yes 2 No 3 Probably 4 Dunknown ongestive Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Velvelus 24a. Was an certificate has autopsy 1 ☐ Yes 2 No or Attending Physician: funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 1/12/2006 AU4176435T15803 MD.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 2 0 2006

Brian Tully

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗍 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2006 1:05 PM William Ross January /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Villa Nursing Center Baltimore Baltimore 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) unk If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 ₹ M 2 □ F Yrs. Dec 14, 1918 Director 217-05-7198 Usual Residence of Decedent death with the Maryland 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location r than "neturel", or Items 23a or 28e-f show the Medical Exand at must be suffiled at 1 Yes 2 No **Funeral Director** Baltimore MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 6004 Burnt Oak Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Completed by black 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education cify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed withir ment of Health and Mental Hygiene. ant: If item 27 Is marked other than ury or other treumatic event, the Ms Elementary/Secondary (0-12) College (1-4or 5+) Montgomery Wards warehouse person 0 unk 18. Mother's Name (First, Middle, Maiden Sumame) unk 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 711 Academay Road Baltimore, MD Frederick Villa Nursing Center 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. 4 □Donation 5 NOther (Specify) in state 21. Signal re of Fun al Service Licensee On ald S. Wadle State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Vascular Denentia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dispass or injury Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed Cause (Dissass or i resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown þ signed 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Monknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed 2 🗌 No 1 Yes 2 No 1 Tyes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient ဂ္ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funerel Direct 4 - Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11/06 D47683 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Knymona Miller 25 Man sweet Swife 200 Rustestown Day Year) 32. Registrar's Signature 31. Date filed (Month, State 2006 Registra

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	ysician: is certific director,	To B	examiner?	Hospital: Inpatient 2[☐ ER/Outpatie	nt 3 DOA Oth	ner .			6 ☐Other (Spe	ecify)
10	g Ph)		27. Manner of Death	28a. ate of Injury (Month, Day Year)	28b. Time o	of 28c. Injur	ry at	28d. Desci	ibe how inj	ury occurred	
io	utending I death. ctor: After y the funer	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(,,			Yes 2 □ No				
Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	reet, factory, office		28f. Locati City of	on (Street a Town, Sta	and Number or R	lura I Route Number,
Q	Ital o irs aff ral Di fed ir										
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) Certifying Phy Certifying Phy Medical Exam	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, dea nation and/or in	th occurred at the til rvestigation, in my o	me, date and pl opinion, death o	lace, and due to occurred at the ti	the cause(me, date a	s) and manner a nd place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b Signature and title of continer	111		29c. Licens	se number		29d. D	ate signed (Mon	th, Day, Year)
	->F0		JW/2	CC, W	\mathcal{V}	N:	262	78	1	-16-6	16
			30. Name and address of person who d	ompleted cause of death (Ite	эт 23а) (Турө			, ,			21802
	Carta Santa Ros		DoudE Conall	MM) Coostol +	Hospice	PO Bo	x/13	3 S.	es/15h	MD	21802
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign		<i>M</i> .				<u></u>	
	Regist	rar	JAN 2 0 200	6 418 1000 1	3	S. S. S.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () () 6 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jamuary 18, 2006° Vietta Agnes Marie Rogers 11:25 ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Care Center Parkville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Aug. 1917 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛱 F 88 Yrs. Maryland 218-22-0438 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if flem 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2X No Director MD Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8832 Walther Blvd 21234 U.S.A. Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: 3 SWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Certified Records Manager U.S. Government Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lipiry or other treumatic event page. John FitzGerald Agnes Little 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 918 Slash Pine Ct., Eldersburg, MD Joseph M. FitzGerald-nephew Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 1/21/06 New Cathedral Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lipensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Vento; color Dystunction /Medical Due to (or as a consequence of): Examiner ASCV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): physicien s s the burial P.O. Box 68760, for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, icate has been sig , page 2 should b 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ Mo 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**o 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending s after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by I 4 - Homicide within 24 hours a To the Funeral I pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 05864 on January 18 -Gn FO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parksille MMD 21234 8800 Wa Ithe Boulevaco Monias 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 2 0

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item #24a Per VERB G854rtilidate/06D44th 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** LOWIE ROSS 0400 AMM 01 18 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE N If Under 1 Year | If Under 24 Hrs. 6. Sex Age_(In yrs. last birthday) **Funeral** Days Hours 1 M 2 Director Usual Residence of Deceden the Maryland 10d. Inside City Limits 10b. County Town or Location or items 23a or 28e-f show or other traumatic event, the Medical Execution roust be notified at Yes 2 No Be Completed by Funeral Director 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a any july or other traumatic event, tra Madigal Exercitors reserved. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian, 14. Race Black. White, etc. 1 Never Married 2 Marned 2 No Baltimore, Maryland 21215-0036 1 🗌 Yes Specify 3 Nidowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Collage 1/4or 5+) Elementary/9 2 od of Disposition 2 Cremation 3 Removal from State 5 Other (Specify) 21. Signature of Funeral Service Approximate Interval Between Onset and Death 23a. Part1. Elder the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory Immediate Cause (Final disease or condition resulting in death) **Physician** CORONARY ARTERY DISEASE YEARS /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of). Physician/Medicai Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. physicien for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🗷 No Day 4☐Pregnant at time of death 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐ Yes 2XXN0 director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 1 Natural 5 Pending 2 🗌 No 1 Tyes death. 2 Accident investigation Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after To the Funerel 1/2 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 1/18/06 ssual 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JHBMC JESSICA COLBURN, MD 4940 EASTERN AVE BALTIMORE, MD 31. Date filed (Month, Day, Year) 32. Degistrar's Signature State JAN 2 0 2006 Registrar

			For State Registrar	State of Marylan		artment of H			giene	6 0	1119
Α,	£ **		Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
1	Physici		LIII DA	FF.	umm	RHUI		JAN	Day	2006	8:30PM
	/Medic	de.	4a. Facility Name (If not institution, give s		VCI II I		or Location of Death		4c. County		3.00
Sec.	Examin	er				BELA			HADE	FORD	
		200	LORIEN-BEL 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year		8. Date of Bir	th		e (State or Foreign
E	Funeral Director		10 10 10	M 20 F	Yrs.	Months Days	Hours Min.	(Month, Oa	y, Year)	MAC !	11.0
	Director		Usual Residence of Decedent	01				10-11	-1710	1.45.40	400
	and	1	10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d.	Inside City Limits
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	ep .	ıne	TI, Maria States	Was Decedent Ever in U Armed Forces?	.S. 13. \	Nas Decedent of F f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecity Yes or No o Ri <mark>can, et</mark> c.)		ce - American ck, White, etc.	Indian,
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7	filed within Hygiene. other than "	So	i2		OF	FICE	SUTEK	11205			CAMPA
b	be file	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle.	, Maiden Suman	ne)	
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Maryland	nit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan artiment of Health and Mental Hygiene. ortant: If item 27 is marked other than "naturel", or items 23s or 28s-1 show injury or other traumatic event, the Madical Examinat must be notified at injury or other traumatic event, the Madical Examinat must be notified at 8.		19a. Informant's Name/Retationship (Type	e, Print)	19b. Mailir	ng Address (Street	and Number or Ru	iral Route Numb	er, City or Town,	State, Zip Co	10000
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Baltimore,	r Hei		20a. Method of Disposition	20b. F	lace of Dispo	sition (Name of natory or other pla	cal	Date	20c. Location	City or Town,	, State
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89	ifficating phy as the	edic									
	eath certifi attending p	S	1F FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of pregna	ancy				23d. Da	te of delivery	
Вох	atter for L	lar	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o		Ectopic pregnanc Other (specify)	У			onth Da	y Year
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	15		30. Name and address of person who co	mipleted cause of death (Iter	п 23а) (Туре,	Print)			• •		
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ı	Physici	an	Decedent's Name (First, Middle, L.	,					2. Date of De Month	Day Your	3. Time of Death
	/Medi		Naomi Ruth Spend	cer					Januar	y 14, 2006	0350 а м
	Examir	er	4a. Fecility Name (If not institution, g	·			4b. Cily, Town, or		eath	4c. County of Dea	
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	Funeral			1 N 2 N 5	e (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	Hours M	8. Date of Bir (Month, Da Sept.	10, 1927 W	thplace (State or Foreign ountry) A
	Director		235-48-1903 Usual Residence of Decedent	X /	8	110.			sept.	10, 1927 WV	A
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	th the	Director	10e. Street and Number				10f. Zip Code	· · · ·		10g. Citizen of What C	ountry?
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	ems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	. 13. \	Was Decedent of His f Yes, specify Cuban	panic Origin?	(Specify Yes or No	- 14. Race - Am	
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an	ld be entat ked o ic avs	To Be	James David Jan	nev					Daniels	wasan samans,	
Maryland	should Ind Men	۲	19a. Informant's Name/Relationship		9.	19b. Mailin				er, City or Town, State, .	Zip Codel
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Ĕ	Pages nent of I ant: If its ury or o		1 ☐Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec		1		em. Gdns.		18/2006	Bel Air, M	id.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28a-f show any injury or other traumetic avent, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Lice	ensee		22 S	Name and Address Chimunek	of Facility Funera	l Home of	Bel Air, I	nc.
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o.	at the death certi by the attending stached for use a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnant at 9☐Unknown	time of dea	th 5∐	Other (specify)				Juy
ص	that the bed by detail		Part II. Other significant conditions	contributing to death b	ut not resulti	ing in the un	derlying cause given	in Part I.	23e. Did to	obacco use contribute to	the cause of death?
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Vital Record	aw requir ts been si 2 should I	Completed	•						24a. Was a	an 24b. Were au	topsy findings available completion of cause of
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<u>ta</u>	ilcian: The certificate hi rector, page	Bec	25. Was case referred to medical examiner?					26. Place of D	eath (Check only or		
	Physic this ce al dire	卢.	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2□EF	NOutpatient	3□ DOA Other	4 Nursing	Home 5 Resid	lence 6 Other (Spec	city)
Ĕ	Attanding Physician: r death. sctor: After this certific by the funeral director,	on:	27. Manner of Death Natural 5 Pending	28a. Date of Injui (Month, Day	Year) 2	8b. Time of Injury	28c. Injury a Work?		28d. Describe h	low injury occurred	
S	tor: /	cat	2 Accident investigation 3 Suicide 6 Could not	ha				s 2 □ No			
Division of	f or Attanated after deat Diractor:	Certification:	4 Homicide determine		iry - At hom- c. (Specily)	e, farm, stre	et, factory, office		28f. Location (S City or Tow	Street and Number or Ru n, State)	ral Route Number,
	a Hospital or 24 hours afte e Funaral Dir letely filled in		29a. Certifier 1 Certifying P	hysician: To the best	of my knowle	edge, death	occurred at the time	date and place	ce, and due to the o	cause(s) and manner as	stated
	To tha Hospital or Al within 24 hours after of To the Funaral Dirac completely filled in by	edicai	(Check only 2 Medicel Exe	miner: On the basis of and manner sta	examination	n and/or inve	estigation, in my opir	nion, death oc	curred at the time, o	date and place, and due	to the cause(s)
	To tha within 2 To the comple	Σ	29b. Signature and title of certifier	1	11.1	2	29c. License r	number	1 2	29d. Date signed (Mont)	ń, Day, ¥ear)
	4	-	30. Name and address of person who	completed cause of di	Oath /ltc= 2	2¢a) (Type, 19	Print)	UPK		1140	20
	6		30. Name and address of person who	IIII On	Carri (item 2	L H	TIM LO	SIM	10 M.10) TT	Lee MIP.
	Sta	e	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	· - LYC	· M	- June	- (-00)	V	
	Registr	ar	JAN 2 0	2006	See al		Contract of the Contract of th				

ADH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. item# 23a,27,28a-f,pen/E,0851 1/21/06 TT State of Maryland / Department of Health and Mental Hygiene JACKIE F. SHUCK 06-0255 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jackie Frederick Shuck JANUARY 10, 2006 1144 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11150 CRAIN HWY # 56 NEWBURG CHARLES 7. Age (In yrs. la 39 . Social Security Number 233–11–3588 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. last birthday) B. Date of Birth
Dec. 1, 1966 9. Birthplace (State or Foreign Westry Virginia **Funeral** 1 XM 2 ☐ F Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other than "natural", or Iteme 23a or 28a-f showers, the Medical Examiner must be notified at Maryland Charles Newburg 1 Yes 2 TNo Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11150 Crain Highway #56 20664 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White Pages 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. X 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 □ Yes 2 □ No Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Laborer Construction 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Jack Shuck Martha Sheppard McKinney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha McKinney, Mother RR #1, Box 66, Fairmont, West Virginia 26554 Health if Health other tre 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 6 1 Burial 2 □ Cremation 3 X Removal from State permit. Page Depertment of Important: If any injury or once. Rest Haven Mem. Gdns. Jan. 14,2006 Fairmont, WV 4 □ Donation 5 □ Other (Specify) 21. Signature of Furieral Service Licensee Ca Name and Address of Ford Funeral Home 209 Merchant Street, Fairmont WV 26554 MO1113 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Narcotic (Oxycodone & Methadone) and alcohol intoxication /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical as attending for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death Day Year signed by the a 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by been s 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior o completion of cause of d-air.

1 X Yes 2□ No certificate has tirector, page 2 s autopsy performed? 2 No 2 No Attending Physicien: To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE TV Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury n (Month, Day Year) 27. Manner of Death 28b. Time of UNK 28c. Injury at Work? Certification: 28d. Describe how injury occurred UNK 5 Pending investigation 1 Natural Injury 1/10/06 1 ☐ Yes 2 No 2 Accident 6X Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 11150 Crain Hwy. 4 Homicide Newburg, MD Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated. 25% Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME JANUARY 11, 2006

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

LAFON Weter

32. Registrar's Signature

ause of death (Item 23a) (Type, Print)

* Spark

111 PENN STREET, BALTIMORE, MARYLAND, 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 18th Wiley Thomas : 05 /Medical Zece 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Rehabilitation and Estended Che Center Baltima NA If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F 242.46.7619 T Yrs. NC Director Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show The Medical Examiner must be notified at Baltimore MD 1 Yes 2 □ No Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? fited within 72 hours after death with USA 5200 Bowleys anc 21206 Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. I Seyes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 12th Qrade College (1-4or 5+) Iransportation Truck Driver Pages 1 and 2 should be filed w thent of Health and Mental Hygie tant: if Item 27 is marked other t jury or other traumatic event, ID 17. Father Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Smith Annie Lee Lindser 19a. Informan Name/Relationship (Type, Print) Da un 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kozena Smith-Williams 1046 Radnor Baltimore MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State Department of Important: If sny injury or once. Barrson 01.27.06 Dwing Milb, MD 4 ☐ Donation 5 ☐ Other (Specify) Forest 22. Name and Address of Facility Vaughin C. Greene Fineral Services
But more MD 21212 21. Signature of Funeral Service Licensee lun Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician LSophanient /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? be detached for Month Day Year 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, within 24 hours after death. To the Funeral Director: After this certificate has been sit completely filled in by the funeral director, page 2 should t 2 No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed2 1 ☐ Yes → No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one 1 🗆 Yes Hospital: Other: Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Oate of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifie. 29c. License number 29d. Date signed (Month, Day, Year) DOO 55 035

DHMH 17 Rev 1/2001

State

Registrar

och Ravir

Blud. Baltino

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lynn Hallarnan
31. Date filed (Month, Day, Year)

JAN20

3900

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Sessoms **Physician** 1:054 M Louise Oi 13 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Hospice Mans Timonium 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months 1 □ M 2 X F A Yrs. NC 241.62.SI4S Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or iteme 23a or 28a-f ahow traumatic avent, the Mudical Examinar must be notified at 1 XYes 2 ☐ No MD Baltimore. Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Avenue Gittings 21239 HHdeath 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status JANUARY 13, 2006 1:05 a.m. 1 Yes 2 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ŒNo Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) Health Care Home Health Assistant 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kosa Purvis Sam Stevenson ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) IIII Gittings Avenue Battimore MD 21239 Waldo Sessoms/Husband Health Item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1 Department of H Importent: If Ite any injury or ot once. 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State D1.19. OLD Windsor Mill, MD King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral Sewices 1905 York Road Baltmore MD 21212 Zun w 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LUNG CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year to in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the spage 2 should be detached to 1 □ Yes 2 🗶 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à AFFIE SESSOMS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2**X** No 1 Yes certificate 1 Yes of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2X No this To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral. 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification: 5 Pending 1 XNatural 1 Tes 2 No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation in my opinion, death account of the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 DR. TARIQ MAHMOOD

DHMH 17 Rev 1/2001

State Registrar

JAN 2 0 2006

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

JC 06-00443 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jack Edwin Stith State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 08:32 A^M Edwin Stith 2006 Jack January 18, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Med. Ctr. Baltimore N/AIf Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) January 15,1917 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 2□F 216-10-2961 89 Yrs. Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits "naturel", or items 23s or 28s-f ehow 1 ☐ Yes 2 X No Director MD Dundalk Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 2907 Dunglow Road 21222 Apt B Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status nit. Pages 1 and 2 should be filed within 72 hours after sertment of Health and Mental Hygiene.
ortant: if Item 27 is marked other than "naturel", or ite injury or other traumatic event, the Mindical Exemities. 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: Specify:White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Machinist Chemical Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edwin Stith Marguerite Haggerty ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2907 Dunglow Road Apt B, Dundalk, MD. 21222 Rosalie Stith wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State January 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore City, MD. 19, 2006 permit.
Depertn
Imports
eny Inju 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician ALUEROSLI = CODI DISFARIT 1DD D.DVA-2111 pro /Medical Examiner To Be Completed by Physician/Medical Examine Medical Certification:

or Attending Physician: The law requires that the death certificate be execut Division of Vital Records, P.O. Box 68760, ours after death.

neral Director: After this certific
filled in by the funeral director, To the Hospital within 24 hours a To the Funeral C

Baltimore, Maryland 21215-0036

resulting in death)	Due to (or as a consec		JICU	10 VII SCO VA	72 910	C143 E	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect c. Due to (or as a consect consec						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	al death 3 Ectop				-	23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ontributing to death but not res	sulting in the underly	ng caus	se given in Part I.		d tobacco u	ise contribute to the cause of death?
					pe	as an topsy oformed?	24b. Were autopsy findings available prior to completion of cause of death? 1.25 Yes 2 □ No
25. Was case referred to medical				26. Place of D	eath (Check on)	v one)	
examiner? 1√DYes 2 No	Hospital: 1 ☐ Inpatient	R/Outpatient 3	DOA	Other: 4 Nursing	Home 5□Re	esidence 6	5 ☐Other (Specify)
27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M		Injury at Work?	28d. Describ		
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fa	ctory, o	ffice	28f. Location City or	(Street and Town, State)	d Number or Rural Route Number,)
29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☆ Medical Exam	/sician: To the best of my knoiner: On the basis of examination and manner stated.	owledge, death occu ation and/or investiga	rred at 1 ation, in	the time, date and pla- my opinion, death oc-	ce, and due to the curred at the time	ne cause(s) e, date and	and manner as stated. place, and due to the cause(s)
29b. Signature and title of certifier			29c. L	icense number		29d. Dat	e signed (Month, Day, Year)
De aust	1		0.0	M.E.		Janu	arv 19. 2006

Registrar

State

ANA 31. Date filed (Month, Day, Year)

NO 32. egistrar's Signature 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RUBIO

DHMH 17 Rev 1/2001

Registrar

JAN 2 0 2006

Amend item#5, peril, 351, 1/31/00 II Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Patricia Sinclair January 12 2006 9:10 ^Ma /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent & Rehab. Center If Under 1 Year 9. Brithplace (State or Foreign Country)
D.C. Crofton If Under 24 Hrs. Anne 8. Date of Birth (Month, Day, May 13 Social Security Number 7668 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 579-34-1668 1 ☐ M 2**½** F 76 Yrs. May Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or itema 23a or 28a-f eho Examinar must be notified at Maryland Anne Arundel 1 ☐ Yes 2 ☑ No Millersville Direc 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1610 Sinclair Lane 21108 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 20 Married 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1□Yes 🛣 No Specify: Black Specify. 3 ☐ Widowed 4 ☐ Divorced "naturel" al Hygiene. d other than "nature avant, I've Mudical E Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry National Worker Elementary/Secondary (0-12) College (1-4or 5+) Social Worker 12th Daycare Association traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked Arthur Williams Frances Goines 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) = Health a Richard H. Sinclair(Husband) 1610 Sinclair Lane Millersville, Md. 21108 other E 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Slate permit. Pages 1 Department of H Importent: If Ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran 1-23-06 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Md. 22. Name and Address of Facility
Wm. Reese & Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses Larry = MO048 220 821 West St. Annapolis, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner thrue Failue Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine anding physician and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 ☐ Yes 21/2 No Division of Vital Hospital or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 100 Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Pis After thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after 124 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2. 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 2 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p 600 32. Registrar's Signature Registrar

			For State Registrar	State of Mary		partmen <i>ertificate</i>			nd Me		ene 0 0 6	01127
	Dhynisis		1. Decedent's Name (First, Middle, Last)						2.	Date of Death	Day Year	3. Time of Death
	Physicia /Medic	al .	<u>Kathleen</u> E.		icher					sanuary	15 2006	9.007 M
	Examin	er	4a. Facility Name (If not institution, give		1	(2)		Location of	-		4c. County of Death	1 ,
	Funeval		5. Social Security Number 6. Sei		yrs. last birthda		1 Year	If Under 2		Date of Birth	Anne Aru	
	Funeral Director			M 2⊠F	85 Yrs	Months	Days	Hours	Min.	(Month, Day, Y uly 13	1920 Cou	place (State or Foreign ntry)
	p .		Usual Residence of Decedent 10a. State 10b. County	140		1 1						
	shov	2	Maryland Anne Ar	i i	c. City, Town or	Location	Ra	altimo	nra			10d. Inside City Limits 1 ☐ Yes 2 🕱 No
	28e-f	ecte	10e, Street and Number	under		10f. Zip		. TOTHIC	<i></i>	100	. Citizen of What Cou	
	3a or	2	118 carvel Beach	Road		101. 2.10		21226		100	USA	muy :
	death	nera		12. Was Decedent Ever Armed Forces?	in U.S. 1	3. Was Deced				y Yes or No-	14. Race - Ameri	
(7) %	or ite	V Fu	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☒ No If Yes, Give		1 ☐ Yes 2		Specify:	, Fuello nic	an, etc.)	Black, White,	nite
S	within 72 hours after death with the Maryland ene. then "neturet", or items 23a or 28e-f show he Medical Examinar mast be notified at	Completed by Funeral Director	3 X Widowed 4 □ Divorced	Year or Dates:	1000		^`					
athle d 21215-	in 72	olete	15. Decedent's Edu (Specify only highest grad	e completed)	(G life	cedent's Usua ive kind of woi a. DO NOT us	i Occupa k done d e retired)	tion uring most	of working	16	6b. Kind of Business/Ir	idustry
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		Sales					Department	Store
, Ko and	be filed Ital Hygi id other event, I	BeC	17. Father's Name (First, Middle, Last)					18. Mother	's Name (F	First, Middle, Ma	aiden Sumame)	
(should that marked umetic e	ို	George W.	White	11 131				len	Klas		
her	d 2 sh th and 7 Is m treum		Jo Ogle	pe, Print)						_{Route Number, C} ena, MD	City or Town, State, Zij	Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 271s marked other then "neturel", or items 23a or 28e-f show any injury or other treumetic event. The Medical Examiner must be notified at once.		20a. Method of Disposition	2	Ob. Place of Dis			-	Jan. Date		oc. Location - City or To	own, State
JA E	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)		<i>cemetery, c</i> 1etro Ci				2006 2006		iltimore, M	Maryland
Schler altimore,	permit. I Departm Importer any inju		21. Signature of Funeral Service Licens		100,0	22. Name an	•				Funeral Ho	ome, P.A.
<u> </u>	8 9 E 8 9		1 Jun 2. 3	1					Road,	Pasade	ma, MD 211	22
	1500		23a. Pan1. Enter the a sease, or comol shock, or heart failure. List only or	allons that caused the cause on each line.	death. Do not	enter the mode	of dying	, such as o	cardiac or re	espiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	TNEUM								Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co		1						
		e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	nsequence of):	1						
18	uted d ansit	Examiner	Cause (Disease or injury that initiated events									
ò	icate be executed physician and s the burial-transit	Exa	resulting in death) Last	Due to (or as a co-	nsequence of):							
68760	ate be hysici the bu	dicat		d	_							
	ding p	(C)	IF FEMALE:	3c. If was autooma of a	roanana.				-			
Вох	The law requires that the death certifit ate has been signed by the attending page 2 should be detached for use as	Physician/M	in the past 12 months?	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death	3 □Ectopic pro					23d. Date of deliv Month	ery Day Year
P.O.	the d	yslo	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	, 01 000011	other (sp						
٣.	res that the de signed by the a be detached f	by Pt	Part II. Other significant conditions cor	ntributing to death but no	t resulting in the	underlying ca	use give	n in Part I.		23e. Did toba	cco use contribute to t	he cause of death?
rds	w require been sig should b								_	1 🗆 Yes	2 □ No 3 □ Prot	pably 4 Unknown
ecc	has been ge 2 should	Completed								24a. Was an autopsy	24b. Were auto	ppsy findings available impletion of cause of
Ξ.	The I	Con								performe	d? death? No 1 ☐ Yes	
Vita	iclen: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:			Otho	_		Check only one)		
of	hys this al dii	2	1 Yes 2 No	1 Minpatient	2 ER/Outpat			4 LI NUI			ce 6 Other (Special	y)
on	Attending r death. sctor: After by the fune	tlon	1 atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	ar) Injur	y M	Bc. Injury Work 1 Y	? ′es 2 □ N		50001150 11011	injury occurred	
	Attendi	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm,	street, factory	office		28f	Location (Stree	et and Number or Rura	al Route Number,
O	rs afte el Dir	Cert	Tomelog	building, etc. (5)	pochy)					City of Yown,	Siale/	
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) 1 Certifying Phy. 2 Medical Exami	sician: To the best of my ner: On the basis of exa and manner stated.	y knowledge, de mination and/or	eath occurred a investigation,	at the time in my op	e, date and inion, deati	place, and h occurred	due to the cau at the time, date	se(s) and manner as s e and place, and due to	tated. o the cause(s)
	To the Vithin 2 To the Complet	Me	29b. Signature and little of certifier		704	29c	License	number	IL CO		I. Date signed (Month,	-
			15		r vu	ر	D	10,	77	JA	MULTERY !	5 2006
	M	8	30 Name and advress of person who	poleted cause of death	(Item 23a) (Typ	e. Print)	91	eub	wylle	e Mi) 240 (St
	Star Registra	4	31. Date filed (Month, pay Year) JAN 2 0 2	32. Fegisina rs 9	Signature -	Cook						

DOUGLAS SUTTON Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Unpend item#3,2a,27, pent 1,851,1/23/06 IT

State of Maryland Department of Health and Mental Hygiene
State of Maryland Department of Health and Mental Hygiene
Registrar

1- For Amend item #4a Per ME G853 3/06/06 IH
Registrar

Reg. No. 06-0200 ADH 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 8, 2006 **Physician** Douglas MacArthur Sutton 0706 Α /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1621 LUANNE CT. FOREST HILL HARFORD If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐M 2 ☐ F 220-90-3197 Director 40 July 16, 1965 North Carolina Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28a-f show any highry or other traumatic avent, the Madical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1621 Louanne Court Apt. C USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Carpenter Construction Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Douglas M. Sutton Betty Joyce Cason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Sutton / Wife 1621 Louanne Ct., Apt. C, Forest Hill, MD 21050 of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Harleigh Crematory 1-16-06 Camden, New Jersey 21. Signature of Funeral Service Licer 22. Name and Address of Facility
McComas Funeral Home, P.A. Mark T. 1317 Cokesbury Road, Abingdon, Maryland 21009 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Priysician /Medical **Examiner** ettending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records. P.O. Box 68760.

Immediate Cause (Final disease or condition	Hypertensive C	ardiovascular	Disease			Onset and Death
resulting in death)	Due to (or as a consec	quence of);				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	Quence of):				
Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a consec	quence of);				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregn Live birth 2 Fet: 4 Pregnant at time of (al death 3 Ectopic			23d. Date of deli	ivery Day Year
Part II. Other significant conditions	contributing to death but not re-	sulting in the underlying	g cause given in Part I.	23e. Did tobacco		the cause of death?
				24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of 2 No
25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)		
1 XYes 2 □ No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	6 Other (Spec	ofty) SCENE
27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how inj		,, OCE112
1 Naturat 5 ☐ Pending 2 ☐ Accident investigati	on					

29c. License number

OCME

111 PENN STREET, BALTIMORE, MARYLAND, 21201

29d. Date signed (Month, Day, Year)

JANUARY 8, 2006

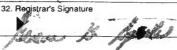
State Registrar

DHMH 17 Rev 1/2001

within 24 hours after deeth. To tha Funeral Director: A completely filled in by the fu

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



ORIGINAL

)0.	352		Please	Type or Print in Black I			3						
			For State	State of Maryland / De		Mental Hygien	2006 01129						
			1 - State Registrar		ertificate of Death	Reg. N							
	Physici	an	Decedent's Name (First, Middle, La			Date of Death Month D	ay Year 3. Time of Death						
	/Medic		<u>Luke</u> Stepho			January	14 2006 1:38 A ^M						
	Examin	er	4a. Facility Name (If not institution, giv		4b. City, Town, or Location of Dea	ath 4	c. County of Death						
				yland Medical Cente Sex 7. Age (In yrs. last birthda		S. 8. Date of Birth	N/A						
	Funeral Director			10XM 2□ F 77 Yrs. 1251 Dillinos	Months Days Hours Mil	n. (Month, Day, Year							
			213-27-2354 Usual Residence of Decedent	17		May 17, 1	1988 Maryland						
	ylan		10a. State 10b. County	10c. City, Town or			10d. Inside City Limits						
	e Ma	cto	Maryland Harf	ord Bel A	ir		1 ☐ Yes 2X No						
	if the or 28	Director	10e. Street and Number		10f. Zip Code	10g. C	itizen of What Country?						
	23a	rai	929 Jackson Bou	levard	21014	Ū	JSA						
	er de	ne	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 	Specify Yes or No- erto Rican, etc.)	 Race - American Indian, Black, White, etc. 						
36	or i	by Funeral	1 Never Married 2 Married	1 ☐ Yes 2 ☐No If Yes, Give	1 ☐ Yes 2 ☐ No Specify:		Specify: White						
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or items 23e or 28e-f show ther, the Medical Examinar must be notified at	g p	3 Widowed 4 Divorced	Year or Dates:	andest's Havel Convention	100	Vied of Business Automateur						
<u> </u>	in 72 n"na	Completed	(Specify only highest gr	ade completed) (Gi	cedent's Usual Occupation ive kind of work done during most of w b. DO NOT use retired)	orking	Kind of Business/Industry						
77	ther.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	tudent	4	High School						
0	Hyg other	BeC	17. Father's Name (First, Middle, Last			ame (First, Middle, Maide							
au	lid be kad ic av	To B	John Philip	Siwinski	Jennif	er Delfs	Harbin						
Maryland	shou and N	_	19a. Informant's Name/Relationship (tiling Address (Street and Number or I	Rural Route Number, City	or Town, State, Zip Code)						
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ore,	of He itam itam		20a. Method of Disposition	20b. Place of Dis	position (Name of		Location - City or Town, State						
E	permit. Pages 1 and 2 should be lifed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Beginstent: If time 27 is marked other then "natural; or itsms 23a or 28a-f show any injury or other traumatic avant, its Medical Examinar must be notified at ODGe.		Mt. Carmel U.M. Cem. Jan.17, 2006 Bel Air, Mary										
Baltimore,	mit. ports y inju		21. Signature of Funeral Service Lice	nsee	22. Name and Address of Facility	D 3	-						
Ω	8 8 E 6	3	Helle 11 Floor	22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21 ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervals on each line. Approximation of the mode of dying are cardiac or respiratory arrest. Onset ar									
			23a. Part1. Enter the disease, or corr shock, or heart allure. List only	iplications that caused the death. Do not e	enter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between						
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	/Medical		resulting in death)	Due to (or as a consequence of):									
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687	physi the t	0		, d									
9 ×	eath certificate attending phys I for use as the	/Me	IF FEMALE:	23c. If yes, outcome of pregnancy			2017						
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)	İ	23d. Date of delivery Month Day Year						
<u>Р</u> О	the de	Physician/Medi	1 ∐ Yes 2 □ No 9 □ Unknown	9 Unknown	S Citier (specify)								
	The law requires that the death certificate te has been signed by the attending phys age 2 should be detached for use as the	/ Ph	Part II. Other significant conditions	contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?						
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00	k req beer shou	lete				24a. Was an	24b. Were autopsy findings available						
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Division of Vital Records,	To the Hospitel or Attanding Physician: The I within 24 hours elter death. To the Funeral Director: After this certificate ha		25. Was case referred to medical		OC Place of D	1 2 Yes 2 □ N	o 1 No Yes 2 No						
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ō	Phy ar this eral o		27. Manner of Death	28a. Date of Injury 28b. Time		28d. Describe how inju							
<u>o</u>	uth. r: Aft	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigatio	FOUND 1/13/06 FOUND	M 1 ☐ Yes 2 XNo	Decease	d shot self						
Vis	Atta acto by th	Certification;	3 Suicide 6 □ Could not be determined	28a Place of Injuny - At home form		28f. Location (Street a	and Number or <u>Aural</u> Route Number,						
	s efte	Cert	4 E TORRICA	building, etc. (Specify)	me	Bol Air W	10) 929 Jackson Biva						
	To the Hospitei within 24 hours e To the Funeral I completely filled		29a. Certifier 1 Certifying Pl	hysician: To the best of my knowledge, de	eath occurred at the time, date and place	ce, and due to the cause(s) and manner as stated.						
	the H in 24 the F iplete	edicai	one)	miner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occ	curred at the time, date an	nd place, and due to the cause(s)						
	To t	Σ	29b. Signature and title of certifier	1de Min	29c. License number	29d. D	ate signed (Month, Day, Year)						
•			AVV	WW //	OCME	Jan	uary 14, 2006						
1			30. Name and address of person who	completed cause of death (Item 23a) (Typ		- D-1+4	M1 - 1 01001						
			31. Date filed (Month, Day, Year)	32 Basistan's Cianatura	III renn street	partimore,	Maryland 21201						
	Sta Registr		JAN 2 0 2	32. Registrar's Signature	forles								
			JAN & U Z	UUO JE STORE SE PRO									

	1.	For State Registrar		State o	n Marylar		artment of H rtificate of L		iu ivieli		g. No.	Ub	UII	30
	1.	Decedent's Name (First, Mide	dle, Last)							Date of Death		Year	3. Time	of Death
ician		Harold Edg	ar s	Smith						MONUN ANUAR	_	, 200	6 2:4	5 P
dical	4a	. Facility Name (If not instituti			ımber)		4b. City, Town, or	r Location of I				nty of Dea		
milei		2109 CRESWEL					BEL AI	R			HAR	FORD		
al		Social Security Number	6. Sex		7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. C	Date of Birth (Month, Day,	Year)	9. Bir	thplace (State	or Foreig
or	2	215-03-8003	136	M 2□F	3	39 Yrs.			1 -	ıg. 11		-	ryland	
	-	sual Residence of Decedent			100.0	h. Tourn and	scation						10d. Inside	City Limit
	1(Da. State 10b. Coun	ty		10c. C	ity, Town or Lo	Addion.							ony Zinin
cto		Maryland Harf	ord		I	Bel Air				1 44	Og. Citizen	of What C		
To Be Completed by Funeral Director	10	De. Street and Number		_			10f. Zip Code	04.64 =		"	Jy. URIZON			
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Completed		15. Deced (Specify only high		e completed)		(Give	kind of work done of DO NOT use retired	during most of	of working				,	
E d		Elementary/Secondary (0-12	2)	Coflege ((1-4or 5+)	Owner					Dair	y Far	mina	
ပိ	1	7. Father's Name (First, Middle	le, Last)		<u> </u>	OWNEL	1 Operat		's Name (Fi	irst, Middle, N	Aaiden Sun	name)		
o Be		Harold Edga		ith						nore T				
٢		19a. Informant's Name/Relation				19b. Maili	ing Address (Street						Zip Code)	
						10.084	stess - Security and	3-2020 TORSON	(12) CS03	0.45 - 0.02.00			o and the second	
	-	Carolyn F. Sm	uth_	/_Wife		Place of Dispe	09 Creswo		Date	AIL	20c. Locate	on - City o	r Town, State	_
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DCe	1	21. Signature of Funeral Servi	Ce LICENS	Me a	/.	2	McComas E		I TTomas					
a G		11/1/1/21			// /							Sept.	and Develop	11000
	-	77 77 1	11:	May	4		1317 Coke	esbury	Road,	Abin	gdon,	Mary	Approxim	nate
		23a. Pert1. Ent. the disease shock, or heart failure. L	or complist only or	lication that ne cause on	caused the de each line.		1317 Coke	esbury	Road,	Abin	gdon,	Mary	land 2 Approximately interval I	nate Between
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DHMH 17 Rev 1/2001

State Registrar

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	shoul nd Me mark	인	19a. Informant's Name/Relationship			19b. Mailin	ng Address	(Street a			Route Numbe	r. City or	Town. State. 2	Zip Code)
2	ith ar ith ar 27 is r trau		Ruth Marie Smith		e						roomes			
ā,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department: If time 27 is marked other than "natural", or items 23a or 28a-f ahow important: If time 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic avant, Ita Medical Examinar must be notified at once.		20a. Method of Disposition			Place of Dispo	sition (Nar	ne of	a)	D	ate	20c. Loc	ation - City or	Town, State
2	Page ento nt: # ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Speci		State	cernetery, crem	natory or o	urer place	1					
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b i			23a. Part. Enter the disease, or conshock or heart failure. List only	plications that	caused the deal							rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_	h-ROSCL	1000 M	ran	7:00	111-1		* 15=	سے، سار	_	Onset and Death
	/Medical		resulting in death)		o (or as a consec		Critical	9/0	MSCU	LAIC	BIJE	-3(-		y targ
	Examiner		Conventially liet conditions	b										
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DOX	attenc for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Feta	al déath 3□	Ectopic pr					23	3d. Date of del Month	ivery Day Year
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	law requires that the as been signed by th 2 should be detache	h h	Part II. Other significant conditions	contributing to	death but not res	sulting in the ur	nderlying c	ause give	n in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?
ecords,	uires I sign Id be	d by	CHRONIC OBST	RULTI	VE PO	UL Mar	nAet	21	SEXAN		101	'es 2 □	No 3 Fr	obably 4 Unknown
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מופווא	in: T ificate or. pa	e Co	25. Was case referred to medical						00 Pl	-f Danth	1 Yes	11.	1 🗆 Yes	2□ No
>	s cert	0 8	examiner?	Hospital:	Inpatient 2	B/Outnation	t 3 DC	Othe			Check only o		Other (See	2064)
5	g Phy erathi	H ii	27. Manner of Death		of Injury nth, Day Year)	28b. Time of		Bc. Injury Work	at		8d. Describe h			Luy)
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VISION	r Atte	ertification:	3 Suicide 6 Could not be determined	250. Plac	e of Injury - At h		eet, factory	, office		2	8f. Location (S City or Tox		Number or Ru	ural Route Number,
5	itaio rs aft al Di	O												
	To the Hospital or Attending Physician: The I within 24 hours after death. To tha Funeral Director: Atter this certificate ha completely filled in by the funeral director, page	dicai	29a. Certifier 1 Destifying P	nysician: To the	ne best of my kno basis of examina	owledge, death	occurred vestigation	at the tim	e, date and	d place, a	nd due to the	cause(s) a	ind manner as	stated.
	the hin 24 the f	Medi	one)	and ma	nner stated.									
	To To	<	29b. Signature and title of certifier	1 /				. License					signed (Monti	-
			CA H-WR	not m				26	358			JAN	-16-	2006
			30. Name of address of person wh	completed at		m 23a) (Type,	Print)	1. 15	FRI	مرحال =	uct,	m	-716)P
78.00	Sta	te.	31. Date filed (Month, Day, Year)		Registrar's Signa	ature	7/2/2		1 - 0			<u> </u>	0.00	,,,
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		,	For State Registrar	State	of Marylan		artment of rtificate o		nd Mental Hy	/giene 006	01132
	Physici		1. Decedent's Name (First, Midd		COTT				2. Date of Do Month	Day 14 Van	3. Time of Death 6 8 05 A.M
	/Medio Examin		4a. Fecility Name (If not institution	n, give street and	number)		4b. City, Town	or Location of	Death	4c. County of De	
			Northwest Hosp					allstow			imore
	Funeral Director		5. Social Security Number	6. Sex 1 ☐ M 2 🔯 i	7. Age (In yrs. 64	last birthday) Yrs.	If Under 1 Year Months Day		Min. (Month, D.		irthplace (State or Foreign Country)
			Usual Residence of Decedent		04				Jan 31	, 1941	/irginia
	ryland		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	72 hours after death with the Maryland natural', or Items 23s or 28s-1 show alsoil Examiner rust be indified at	Funeral Director		imore		R	<u>eisterst</u>				1 ☐ Yes 20€ No
	with the	ä	10e. Street and Number				10f. Zip Code	•		10g. Citizen of What (,
	eath 18 23	eral	6136 Deer P		ecedent Ever in U.	S. 13	Was Decedent o	21136 Hispanic Orig	in? (Specify Yes or N	U.S.A.	
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8	ours a	वि	3 ☐ Widowed 4 ☐ Divorced	If Vac	Give r Dates:		1⊡Yes 2⊠N	o Specify:		Specify:	White
21215-0036	172 hours after death with the Marylan "natural", or Items 23a or 28a-1 show Idical Examinar must be notified at	Completed	15. Deceder (Specify only highe	nt's Education est grade complete	ed)	16a. Dece (Give	dent's Usual Occ kind of work dor DO NOT use reti	upation ne during most	of working	16b. Kind of Busines	s/Industry
121	within and the within and the way	d L	Elementary/Secondary (0-12)	Colleg	e (1-4or 5+)		<i>bo noi use reii</i> sewife	rea)		Orm Ho	
d 2	should be filed within of Mental Hygisne. marked other than matic svent, Ins M		12 17. Father's Name (First, Middle,	Last)		nou	SEMILE	18. Mother	's Name (First, Middle	Own Ho	ome
an	ould be Mental arked o	To Be	Richard	Lewis	Smit	-h			Virgi		
Maryland	2 should and Men Is marke	-	19a. Informant's Name/Relation		DILL		ng Address (Stre	et and Number		per, City or Town, State	
	2 mg Z		Edward N. Silc	ott Hus	band		Deer Pa	rk Roac		stown, Mary	land 21136
ore	of Heal		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal fro	_	lace of Dispo emetery, cre	sition (Name of matory or other p	lace)	Date	20c. Location - City of	r Town, State
Ë	nit Page artment c ortant: If injury or e.		`4 ☐ Donation 5 ☐ Other (Specify)	Car		rematio			Hampstead	, Maryland
Baltimore,	permit. Pages Department of Himportant: If ite any injury or of once.		21. Signature of Funeral Service	Licensee	<u></u>	450	2. Name and Add		11024 NC	isterstown	Road aryland 21136
	Medical Examiner https://wedicalection.com/	Examiner	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	on each line.	uence of): uence of): uence of):	SIS		maddle		Approximate Interval Between Onset and Death
P.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant condit	1 □ Lin 4 □ Pr 9 □ Ur	outcome of pregna ve birth 2 Feta egnant at time of d aknown	I death 3[eath 5[□Ectopic pregnar □ Other (specify)		23a Did	23d. Date of d Month	Day Year
ds,	uires ti signe id be c	l by	Failure t	At	we	Rhei	met	57d		Yes 21 Ne 3 □ I	_
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ita	sician: Th certificate rector, pag	BeC	25. Was case referred to medica examiner?	al				26. Place	of Death (Check only		
of V	Physician: r this certifica ral director, I	2	1 ☐ Yes 2 ☐ No			ER/Outpatie	IL 3 DOA			idence 6 Other (Sp	ecify)
n	ding P h. After t funera	lon;	27. Manner of Death 1 □ Natural 5 □ Pendi	19	ate of Injury Month, Day Year)	28b. Time o	W			how injury occurred	
Division	f or Attendi after death. Director: A i in by the fu	Certification;	3 Suicide 6 Could	ninod 200. FI	ace of Injury - At ho uilding, etc. (Specif	ome, farm, st		∏Yes 2∏N e	28f. Location	(Street and Number or I own, State)	Rural Route Number,
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical Ce		Examiner: On th						cause(s) and manner , date and place, and di	
	To the within To the	Me	29b. Signature and title of certific				29c. Lice	nse number		29d. Date signed (Moi	nth, Day, Yeath
Q			1 Dans	mape	v M	D	D	542	88	Janua	my 19 2006
l.			30. Name and address of person	who completed o	ause of death (Item	n 23a) (Type,	Print)				U
		2	Dr. Ramaswamy		<u> </u>		Court Ro	ad Rar	ndallstown	, MD 21133	
	Sta Registi		31. Date filed (Month, Day, Year JAN 2		Registrar's Signa	ature _	2000				
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			For State Registrar		State	of Mary	land /	Depa Cer	artment o	of He	ealth a Death	and M	lental Hyg	jiene)	006	0 1	33
100	Dhusisi		1. Decedent's Name (First	Middle, La	st)								2. Date of Dea Month		Year	3. Time of	Death
	Physici /Medic		GERALD			IERRY				SIE	GEL		JANUARY		, 2006	10:05	Ам
	Examin	er	4a. Facility Name (If not in:	_			0		4b. City, To	wn, or L			DE	4c. 0	County of Deal		
\$	Ç. e	3.4	SLADE MANO 5. Social Security Number	JK AS:		7. Age (In		birthda vì	If Under 1	/ear	BAL If Under 3	TIMO 24 Hrs.	RE 8. Date of Birth)		BALTIMOI thplace (State o	
4	Funeral Director		154-07-25		1 M 2□ F	, , , , go (, , .	85	Yrs.		ays	Hours	Min.	NOV. 11	192	0	ountry)	NJ
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	death	Funeral	11. Marital Status			cedent Ever	r in U.S.	13. V	Vas Deceden	t of His			ecify Yes or No- Rican, etc.)	1.	4. Race - Ame	ncan Indian,	
98	2 should be filed within 72 hours effer death with the Maryland and Mental Hygiene, and Mental Hygiene is marked other than "naturel; or items 23s or 28s-f show eumatic event, it is Madical Examinant must be notified at	y Fu	1 Never Married 2		1 X Yes	2 □ No Bive	ARMY	f	Yes 20X		Specify:	, rueno	rican, etc.;		Black, Whit Specify:	e, etc. WHITE	-
Ö	hours turel,	ed by	3 X Widowed 4 □ Di	vorced ecedent's E	Year or	Dates:	T 40										-
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пd	oe file tal Hy d oth	Be (17. Father's Name (First, A	fiddle, Last)					1			(First, Middle,	Maiden S			
<u>yla</u>	should I and Meni market umatic	2	HARRY					SIEG			ΙD					(NOWN)	
Mar	d 2 sh h and 7 is rr treum		19a. Informant's Name/Re				1:						- OWINGS				
ق	tem 27		20a. Method of Disposition		3011	2	lob. Place	of Dispos	sition (Name	of					ation - City or		
OE.	Pages nent of i int: If its iry or o		1 💢 Burial 2 □ Crem 4 □ Donation 5 □ O			n State			HEBRE			1/19				OWN, MI)
	permit. Pages 1 and 2 should Department of Health and Men Important: if item 27 is marke eny injury or other treumatic. once.		21. Signature of Funeral S						. Name and A				L LEVINS				,
<u> </u>	89 = 8) // Ja	1				8	900 RE	IST	ERST		ROAD - I				208
Ė	物			e only		that caused the death. Do not enter the mode of dying, such as cardiac or respirator a on each line.										Approximate Interval Bety	ween
i i	Physician	. 4	Immediate Caus (Final disease or condition resulting in death)		_ a/·	15PI	RAT	.10		1	>~ <	E-0	MOR	1 P	•	Onset and E	eath
	/Medical Examiner			- (Due to	o (or as a coi	nsequenc	e of):									
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o	thet the de ed by the e detached f	hysl	9 Unknown		9□ Unki					,,							
S, D	res the igned be det	by P	Part II. Other significant c	onditions o	contributing to	death but no	ot resulting	j in the un	iderlying caus	e given	in Part I.		23e. Did tot	acco us	e contribute to	the cause of de	aath?
Records,	v requir been si should I	ted						_					1 □ Ye	s 2 🗌	No 3□Pr	obably 4	nknown
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_													perform	ned?	death?	21/10	
Vita	Physician: rthis certifici ral director,	o Be	25. Was case referred to n examiner? 1 Yes 2 No	redical	Hospital:	71	. □ ED#		• • • • • • • • • • • • • • • • • • • •	Other			Check only on		,	ASSIS	TED
ō	g Phys er this eral dir	-	27. Manner of Death		28a. Date	e of Injury	28b	. Time of	3 □ DOA 28c.	Injury a Work?	4 LI Nur	-	ne 5 ☐ Reside 28d. Describe ho	_	occurred	City) LLV	1-6
io	Attanding F ir death. ector: After by the funera	atlo		Pending investigation		nth, Day Yea	ar)	Injury	М		s 2 🗆 N	No					
Division of	4 2 2 A	Certification;		Could not b determined	28e. Plac	ce of Injury - ding, etc. (S)	At home,	farm, stre	et, factory, of	fice		2	28f. Location (St. City or Town	reet and n, State)	Number or Ru	ral Route Numi	oer,
۵	pitei o urs aft erei Di				1												
80	To the Hospitel within 24 hours a To the Funerel Completely filled	dical	29a. Certifier (Check only 2 Minone)	edical Exar	miner: On the	ne best of my basis of exai inner stated.	y knowled imination a	ge, death and/or inv	occurred at t estigation, in	he time my opir	, date and nion, deat	d place, a h occurre	and due to the ca ed at the time, da	ause(s) a ate and p	nd manner as lace, and due	stated. to the cause(s)	
5	To the	Me	29b. Signa re nd title of	certifier	\ \ \	601)		29c. Li	cense r	number		2	9d. Date	signed (Monti	n, Day, Year)	-
)			Hon	-	2 ا ملو	(01	سلام	-01	7	2	116	,8	0	(/(8	1/06	,
			30. Name and address of p	erson who	completed car	use of death	(Item 23a	1	117	D	VI 0 V	.1.	E16147		1	(DINE
	ALCO SE		31. Date filed (Month, Day,	Vaar)	OH	Registrar's S	14.7)_ (s	5/11/	- 1	AK (C	14.	C 10 147	7	AUE	PUE.	(11)
Eq.	Sta Registr	_	JAN 2	3 2006	32.	riogistial's S	Jigirature	A 30	100 m								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 6:55 A M Charles Howard Thomas Jan 9 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster Nursing & Rehab. Westminster Carroll If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1⊠M 2□F 63 Director 23, <u>216-38-0288</u> 1942 Maryland Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heatih and Mental Hygiene. and to frem 27 is marked other then "neturel", or items 23s or 28s-f ehov ury or other treumatic event, the Madical Examination with the notified at 1 ☐ Yes 2 No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 3945 Salem Bottom Road 21157 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes X No Specify: Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carroll County 12 Custodian Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Leonard Thomas Mildred Elnora Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pearl Thomas 3945 Salem Bottom Road Westminster, Md 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
eny injury or ot Jan. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fairview Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funeral Service Licenses

22. Name and Address of Facility

Burrier-Queen Funeral Home & Crematory, P.A.

1212 W. Old Liberty Road Winfield, MD 21784

Approximate Interval Between Onset and Death

Interval Between Onset and Death Mt. Airv. MD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 → Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 - NO 25. Was case referred to medical Be 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 2 ER/OutpatienI 3 DOA this 28c. Injury all Work? Certification: 27. Mannes-of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) After 1 Natural 5 Pending within 24 hours effer death.

To the Funeral Director: A completely filled in by the fu death. 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed Month, Day, Year) completed cause of death (Item 23a) (Type, Print) Read, Westgrunster

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H rtificate of L			iene	6 01135
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month		3. Time of Death
	/Medic	al	Ann Helen Trovato					January		006 8:56 A M
	Examin	er	4a. Facility Name (If not institution, give st		0	4b. City, Town, or		1	4c. County of	
	Funeral		5. Social Security Number 6. Sex		e (In yrs. last birthday)	Esse If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthplace (State or Foreign Country)
	Director		216-24-9208	M 216 F	75 Yrs.	Months Days	Hours Min.	March 6.	1930	Maryland
	D		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Aaryla f sho	ō				_				1 ☐ Yes 2 ☑ No
	28a-	Directo	Maryland Baltin 10e. Street and Number	ione		10f. Zip Code	_	11	0g. Citizen of Wh	
	h with		601 Delaware Avenu	e. Apt 2			21221		u. s	S. A.
	ems a	Funeral		2. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Si	pecify Yes or No-	14. Race	- American Indian, White, etc.
ရှ	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 💢	No	1 ☐ Yes 2 🛣 No	Specify:		Specify:	
215-0036	illed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or liems 23s or 28s-f show Int, the Medical Exerplace must be notified at	ed b	15. Decedent's Educ	Year or Dates:	16a, Dece	dent's Usual Occupa	ation		16b. Kind of Busi	white iness/logustry
2 2 2	hin 72 P. In "ng Medit	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5	(Give	kind of work done o DO NOT use retired	furing most of wor.	king		spital
7	ad wit giene er tha	Completed	12th Grade			volunt	eer		Thrift	t Store
Maryland	be de	Be	17. Father's Name (First, Middle, Last)	1				ne (First, Middle, M	Maiden Sumame)	1
Ĕ	should be nd Menta i markad umatic ev	잍	Unknown McDonoug 19a. Informant's Name/Relationship (Typ		19h Mailir	ng Address (Street a		ra Rumpf	City of Tours Ci	to to Tip Code
<u>∞</u>	id 2 sith ar 27 is trau	1	Mrs. Joy Corteggia			Saxon Ci			10000	
<u>6</u>	ges 1 and 2 t of Health if item 27 or other tr		20a. Method of Disposition		20b. Place of Dispo					ity or Town, State
Ē	Pages nent of I int: if its ury or o		1 X Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	moval from State	Bel Air M		7 1	1/2006 B	el Air.	Maryland
Baitimore,	permit. Pages Department of Important: if it any injury or o		21. Signature of Furgray Service 1 teams			. Name and Addres				
1)	20529		Jef Con		9	705 Belai	r Rd., B	actimore	, Maryka	ind 21236
			23a. Prt1. Enter the disease, or complice shock, or heart failure. List only one	cause on each III	ne.	Λ	7.4		est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		diac,	4/Ving	genn 9	5		10-15 min
	Examiner		ſ	Due to (or as	a consequence of):	Arrhy	Dro	l 22e		Un-known
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	cuted nd ransit	Examin	that initiated events							
Ď,	e execian a	EX	resulting in death) Last	Due to (or as	a consequence of):					
9/80	icate be executed physician and s the burial-transit	dicai	d.							
×			IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome	of pregnancy				23d. Date	of delivery
žo Ro	death d for u	Physician/M	in the past 12 months?	4 Pregnant at		Ectopic pregnancy Other (specify)			Month	,
J.	t the by the tacher	hys	9 Unknown	9 Unknown						
_	The law requires that the death certif te has been signed by the attending age 2 should be detached for use a	by F	Part II. Other significant conditions cont	ributing to death b		nderlying cause give	in in Part I.			oute to the cause of death?
ecords,	requir een s nould	ted	1) May par	N. 100-110	1) // 17 /		1 \ Ye	s 2 No 3	Probably 4 Onknown
ec C	The law cate has b page 2 sh	Completed						24a. Was ar autops perform	y pric	ere autopsy findings available or to completion of cause of ath?
<u> </u>			7-2-14					1 Yes 2	DN0 1	Yes 2 No
VItal		To Be	25. Was case referred to medical examiner?	ospital:	nt 2 ☐ ER/Outpatien	t 3 DOA Othe		th (Check only one ome 5 Preside	/	(Canada)
0	ding Phys h. After this funeral di		27. Manner of Death	28a. Date of Inju	ry 28b. Time of	28c. Injury Work	at	28d. Describe ho		
Ö	tandin death. tor: Aft the fur	atio	1 Natural 5 Pending 2 Accident investigation	(MOINI, Da)	r dary injury		res 2 No			
DIVISION	or Attu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju- building, etc	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (Str City or Town	eet and Number , State)	or Rural Route Number,
_	pital ours al		29a. Certifier 1 Certifying Physi	aione To the base	-6 leasuladas dast					
	Hos 24 hc Fun etely	Medical	(Check only one)	eran: 10 the basis of and manner sta	of my knowledge, death f examination and/or in- ated.	estigation, in my op	e, date and place, pinion, death occur	red at the time, da	use(s) and mann ite and place, and	d due to the cause(s)
	To the Hospital or Attandi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	Me	29b. Signature and Itle of certifier	2		29c. Licensa	_			(Month, Day, Year)
			146 M	()		D-3	58-7-54	- ε	1-18-	- 2006
	V		30. Name and address of person who con	pleted cause of d	eath (Item 23a) (Type,	Print)	1 BLV	2	11 2 2	1221
	`		31. Date filed (Month, Day, Year)	BOM 32 Redistr	40 9 E	AST BRA	4 00 00	$\nu : \mathfrak{d}$	UD-2	121
	Sta Registr			ากล	ar a Signature	Carles				

				artment of Health and Me		jiene) 06	01136
			1. Decedent's Name (First, Middle, Last)	2	2. Date of Deat		3. Time of Death
	Physicia /Medic		Harry Edward Tate	J	anuary		11:15 P ^M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	h
			605 Sand Road	Severn		Anne An	
	Funeral		5. Social Security Number 6. Sex 1 XM 2 F 7. Age (In yrs. last birthday	Months Days Hours Min.	3. Date of Birth (Month, Day,	, Year) Co	hplace (State or Foreign
	Director		221-38-0650 54 Yrs. Usual Residence of Decedent		ec. 9,	1951 Man	ryland
	yland yland		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	a-fs	ţ	Maryland Anne Arundel	Severn			1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co	puntry?
	23a		605 Sand Road	21144		United Sta	ates
	er deg	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Ame Black, White	
36	s afte	by Fi	1 □ Never Married 2 ▼ Married 1 ▼ Yes 2 □ No 1969 − If Yes, Give 1975	1 ☐ Yes 🛣 No Specify:		Specify:	
우	within 72 hours after death with the Maryland ene. Than "naturel", or Items 23e or 28e-f show the Medical Evanthay from the notified at	edt	1373	edent's Usual Occupation		16b. Kind of Business/	hite Industry
75	n "n	Completed	(Specify only highest grade completed) (Giv	e kind of work done during most of working DO NOT use retired)	7	Heating and	
2	d with giene	mo.	Elementary/Secondary (0-12) College (1-4or 5+)	ce President		Conditioni	ng Distributo
B	e file al Hys l othe vant,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (
<u>a</u>	Menta Menta arkad	Tof	Robert Sinroe Tate	Virginia	Floren	ce Williams	S
a	and and is ma			ing Address (Street and Number or Rural i	Route Number	r, City or Town, State, 2	Zip Code)
2	and lealth m 27 har tr			Sand Road, Severn, M		• •	
Baltimore, Maryland 21215-0036	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural; or items 23s or 28s-1 show int: If item 27 is marked other than.		1 Liburia: 2 XCremation 3 Linemoval from State	ematory or other place) Januar	·v	20c. Location - City or	Town, State
Ë	t. Pa ntmen ntant:			del Crematory 18, 2	2006	Odenton, M	D
Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Conaldson Funeral Ho .411 Annapolis Road,	me & C	rematory, l	P.A. 13
г			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Carcinoma of Eso	phagus			Onset and Death 3 months
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	**************************************			
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	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or in Jury that initiated events				
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9	ificati g phy as the	edic					
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the page 13 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of del	ivery
	ne deal the att hed for	sicis	1 Yes 2 No	Other (specify)		Month	Day Year
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	res tha igned be det	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		bacco use contribute to	
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ec	e law has b	npie			24a. Was a autops	y prior to d	topsy findings available completion of cause of
프					1 Yes 2	med? death? 2X No 1 ☐ Yes	2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical	26. Place of Death (
of		<u>۲</u>	1 ☐ Yes 2 🛣 No Prospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time	att 30 DOX 40 Nothing Home		ence 6 Other (Spec	cify)
OU	ding Ph h. After th funeral	tion	1 X Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 □ Yes 2 □ No	. D0301100 110	5W Injury occurred	
Division	nt or Attanding after death. I Diractor: After d in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s		f. Location (St	treet and Number or Ru	ıral Route Number.
á	- 9	Certification;	4 ☐ Homicide determined building, etc. (Specify)		City or Towr	n, State)	
	To the Hospital or within 24 hours after to the Funeral Dir completely filled in		29a. Certifier (Charles) 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, an	d due to the ca	ause(s) and manner as	stated.
	he Ho in 24 ha Fu pletel	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred	d at the time, da	ate and place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month	h, Day, Year)
)	. \		I fulle Frakmer th	D0051770	J	January 18,	2006
ıT	1		30. Name and address of person who completed cause of death (Item 23a) (Type				
			100	Orleans St., Balti	more, M	1D 21231	
	Sta Registr	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 2 0 2006				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Gregory Tantaros January 14 2006 10.35P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care Chesapeake <u>Arnold</u> Anne Arundel Year If Under 24 Hrs. If Under 1 5. Social Security Number 6. Sex 1 (**X**M 2 □ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Yrs Director 96 137-26-3183 Feb. 2, 1909 Greece Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Nexical Expression into the notified at 1 ☐ Yes 2 XNo Director Md. <u> Anne Arundel</u> Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17 Sloan Lane 21122 USA Completed by Funeral 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "national jury or other than" 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Bottling Company Factory Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nicholas Tantaros Constance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance Cotter (Daughter) 17 Sloan Lane Pasadena, Md. 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 1/18/06 Hillside Cemetery Scotch Plains, NJ 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 23a. Part1. Enter the Sease, or co-shock, or heert fail se. List on s Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy for in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) P.O. cate has been signed by the a page 2 should be detached in 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed) certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 No director, 25. Was case referred to-medical Be 26. Place of Death (Check only one) Other: 4 Voursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Inpatient this After thi funeral 27. Mann f Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Matural 5 Pending death. 1 TYes 2 No investigation 2 Accident hours after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours the Funeral Director filled in by à 4 Homicide 29a, Certifies 1 Destifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Sinnature and title of 0 D50725 rans Huy M. Mersville, MD 21108 12 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 6:30 AM KNUTE JANUARY 2004 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) If Under 24 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, Months 1 9M 2□ F Days Hours Yrs. 214-50-4928 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City. Town or Location 1 Yes 2 No MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code STATE 21215 3509 UNITED Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Government Traffic Maintenance Emineer 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) NORRIS JULIUS ERMYN JEANEITE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH TILGHMAN SPOUSE 13509 WABASH AVE BALTIMORE, MD DIDIS 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ANATOMY GIFTS REG 4 Donation 5 ☐ Other (Specify) ANDTONY EIETS DECISION OF SOUTH TO STORE HAJOURI MD 310 21. Signature of Feneral Service Licensee 22. Name and Address of Facility Approximate Interval Between Onset and Deat 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiralory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24a. Was an autopsy performe Were aulopsy findings available prior to completion of cause of death? 1 □ Yøs 2 □ No 2 12 No 1 Yes 25. Was case referred to 11 edical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Mann of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Yeer) 28b. Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined

/Medical Examiner The law requires that the death certificate be executed P.O. Box 68760, this certificate has Division of Vital To the Funeral Director: After this certific completely filled in by the funeral director, death. To the Hospital within 24 hours at To the Funeral D Medical

Physician

Examiner

Directo

Funeral

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Completed

Be

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Director

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d other then "naturel", or items 23s or event, the Medical Examiner must be

with the Maryland

death

filed within 72 hours after

permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked o

Physician

Maryland 21215-0036

Baltimore,

/Medical

Examine Completed by Physician/Medical Be Certification; To

3 Suicide

29a. Certifier

4 Homicide

31. Date filed (Month, Day

State Registrar 29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dev. Year) 29c. License number

rson who completed cause of death (Item 23a) (Type, Print)

			1 - For Stete Registrer	State of Maryland		tment of H ificate of L		Mental Hy	giene	6 01139
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	THIESS				2. Date of Do Month	Day 17 2	Year J H 5 A M
	Funeral	er	4a. Facility Name (If not institution, give stre BOLL NULL VA MR. 5. Social Security Number 217-40-1742 6. Sex	TAL CON HA	birthday)	4b. City, Town, or A If Under 1 Year Months Days	Location of Dea	8. Date of Bi	4c. County of	9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent 10a. State 10b. County	03	own or Loca	ation		9-23-	1942	MARYLAND 10d. Inside City Limits
	Ba-f show	Director	MD BALTIMO			М	IDDLE R	EVER		1 ☐ Yes 2 📉 No
	th with the 23a or 2	al Dire	10e. Street and Number 3814 DUNSMUIR CIRC	LE APT. C		10f. Zip Code	21220		10g. Citizen of W	U.S.A.
200	be filed within 72 hours after deeth with the Maryland stal Hyglene. ad other than "naturel", or iteme 23a or 28a-f show event, the Madical Examinar must be mulliad at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: VIETNA	Jf '	as Decedent of Hi Yes, specify Cuba ☐ Yes 2【XNo	ispanic Origin? (in, Mexican, Puer Specify:	Specify Yes or Norto Rican, etc.)		e - American Indian, k, White, etc. · WHITE
20171	I within 72 h lene. r than "natu ina Madica	Completed	15. Decedent's Educat (Specify only highest grade control of the c	ion ompleted) College (1-4or 5+)	(Give ki life. Do	nt's Usual Occupind of work done of NOT use retired	during most of wo ()	orking	AUTOMO	,
מומ		Be	17. Father's Name (First, Middle, Last) JOHN AUGU	JST THIESS					e, Maiden Sumame HERINE	
yiai yi	s 1 and 2 should f Health and Men item 27 is marke other treumatic	₽ P	19a. Informant's Name/Relationship (Type, JANET M. THIESS/ WI		_	Address (Street a		tural Route Numb	per, City or Town,	
ווסנט' ב	permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 ts m any injury or other treum		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	20b. Plac	e of Disposi etery, crema	tion (Name of atory or other place	e)	Date 9-2006	20c. Location - (City or Town, State SVILLE, MD
	permit. P Departme Importen any injuri once.		21. Signature of Funeral Service Licensee				1			NERAL HOME
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one of the shock of heart failure. List only one of the shock or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer	nce of):		CO AVENU			Approximate Interval Between Onset and Death
P.O. BOX 00/00	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial:transit	Physiclan/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of deat 9 Unknown	eath 3⊟E h 5⊟0	Ectopic pregnancy Other (specify)		23a Did	Mon	e of delivery tth Day Year ibute to the cause of death?
cords,	w requires that s been signed b should be deta	eted by	Part II. Other significant conditions contin	outing to death out not resulting	ig in the diff	serrying cause give	en in rait i.		Yes 2 □ No	3 Probably 4 □Unknown Vere autopsy findings available
ָ ב	vicien: The lav certificete has rector, page 2	Completed						auto perf 1 ☐ Yes	ppsy prormed? de 1	rior to completion of cause of eath?
01 411	Physicien: r this certifice ral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	pital: Ŋ⊠Inpatient 2□ER	/Outpatient	3□ DOA Othe	20	eath (Check only Home 5 Res	<i>one)</i> idence 6 □Othe	er (Specify)
	fte		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Bb. Time of Injury	28c. Injun Work M 1 []	yat k? Yes 2 □ No	28d. Describe	how injury occurre	ed
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stree	et, factory, office			(Street and Numbe wn, State)	er or Rural Route Number,
	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by	edical (29a. Certifier 1 Certifying Physic (Check only one)	ien: To the best of my knowler: On the basis of examination and manner stated.	dge, death on and/or inve	occurred at the timestigation, in my of	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and mar date and place, a	nner as stated. Ind due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier			29c. License				(Month, Day, Year)
	10		30. Name and address of person who comp		3a) (Type, P	15850	·		111710	
	Sta		31. Date filed (Month, Day, Year)	33. Registrar's Signatur	101	U GREEN	UC 5TR	eet DA	ILT-MOR	e, mbabal
	Registi	rar	2000	San Comment of the	AND THE PERSON OF	S. Carrie				

			For State	State of Ma						Mental Hy	giene	006	01140	
	* 2000		State Registrar Amend Item Decedent's Name (First, Middle, Lase)	#14 Per M	L_ G8 5	1_1/30	106ai	HOT DE	eatn	2 Date of De	Reg. No),	3. Time of Death	_
	Physici	an	1. Decedent's Name (First, Middle, Las	51)		him				Month	Da		16:32 M	
	/Medic	_	4a. Facility Name (If not institution, give	a street and number)	/	ning			cation of De	Jo.n	40	County of Deal	3	-
1	Examin	er	11. 1 CM	aryland Mea	0. 1	Carta	7	3altiv			10	. County of Bog		
	Funeral	-	5. Social Security Number 6. S	ex 7. Age		last birthday)	If Under	1 Year If	Under 24 H	rs. 8. Date of Bi	rth	9. Birt	thplace (State or Foreign	-
Rest.	Director		091-42-7623	X ^{2□} ⁶	6	Yrs.	Months	Days	Hours Mi	in. April	16,	1939 ີ	Thailand	
	D * S		Usual Residence of Decedent 10a. State 10b. County		10c Cin	y, Town or Lo	nation				-		10d. Inside City Limits	_
	sho	ō			100. 010								1 ☐ Yes 2 🗷 No	
	28a-1	ect	MD Baltimo 10e. Street and Number	re		LUT	hervi 10f. Zip				10a Cit	tizen of What Co	nuotov?	-
	3a or	ā	318 Ridgely Road					21093			_	USA	, and the second	
	should be filed within 72 hours after death with the Maryland rind Mental Hygiene. In arked other than "natural" or Items 23e or 28e-f show marked other than "natural" or Items 20e or 28e-f show umatic event, Ite Medical Examinar must be rediffed at	Funeral Director	11. Marital Status	12. Was Decedent E	ever in U.	S. 13. V	Vas Dece	dent of Hispa	anic Origin?	(Specify Yes or No erto Rican, etc.))-	14. Race - Ame	erican Indian,	_
٥	or Ite		1 ☐ Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 🔀 N If Yes, Give	lo		r Yes, spe⊲		Mexican, Pui S <i>pecify:</i>	erto Hican, etc.)			e, etc. Asian	
2	rel',	d by	3 Widowed 4 Divorced	Year or Dates:				200 190	specity.			Specify:	- WILL CE	
<u>v</u>	"nati	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		(Give	kind of wo	al Occupatio rk done duri se retired)	n ing most of w	vorking	16b. K	and of Business/	Industry	
72	withir ene. than	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5- 5+	+)		vsici					Medical		
מ ס	filed Hygi other	Be Co	17. Father's Name (First, Middle, Last)				yoror	7	B. Mother's N	lame (First, Middle	1			_
<u>la</u>	lid be lental rked tic ev	To B	Oon Saekoo						Krung	y Unkno	ωn			
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or liems 23a or 28a-f show eumatic event, Itsa Madical Exantinat must be notified at		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address	(Street and	Number or	Rural Route Numb		or Town, State, 2	Zip Code)	
	ss 1 and 2 should of Health and Mer I Item 27 is marke r other treumatic		Andrea Thimatari	ga/wife					d, Lut	therville	, Ma	ryland	21093	
o	Pages 1 nent of He nnt: if Iter iry or oth		20a. Method of Disposition 1 □ Burial 2 ★ Cremation 3 □	Removal from State	C	lace of Disposemetery, crem	natory or o	ther place)		Date		ocation - City or		
Ē	Pag Iment tent: jury o		4 □Donation 5 □ Other (Specify	<i>(</i>)	Hil	ltop S			- 1	/23/2006			Maryland	
Ball	permit. Pages Department of Importent: If I any injury or o		21. Signature of Funeral Service Licen					nd Address o					Home, Inc.	
	402.0		23a. Part1. Enter the disease, or com	Stephen C					<u> </u>	Towson,		land 2	1204 Approximate	-
			shock, or heart failure. List only	one cause on each lin	0.				,	iac or respiratory a	mest,		Interval Between Onset and Death	
80	Physician /Medical		disease or condition resulting in death)	a. Zsche Due to (or as a	3mis	Car	diom	yopat	by			-		_
*	Examiner			Due to (or as a	i consequ	derice or).		, ,	ł					
ļ		ner	Sequentially list conditions, if any, leading to influediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or se a	сопведи	denice of):								_
V	cuted	Examiner	that initiated events	c										
8760,	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Ä	resulting in death) Last	Due to (or as a	a consequ	uence of):								
876	cate b	dical		d							-			
ox e	leath certiti attending p	Physician/Me	IF FEMALE:	23c. If yes, outcome of	of pregna	ncv						004 D-1		1
Bo	atten atten tor u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	Ectopic pr					23d. Date of del Month	Day Year	
o.	the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown										
<u>ر</u> ري	res that the de signed by the a be detached t	by P	Part II. Dther significant conditions of	ontributing to death bu	it not resu	ulting in the un	derlying c	ause given i	n Part I.	23e. Did	obacco (use contribute to	the cause of death?	
ğ	w require been sig should b	edt	Coronary A	Hery Dise	are	Perip	heral	Vascu	ler	_ 1 🗆	Yes 2	⊗ No 3□Pr	obably 4 Unknown	
000	has ben ge 2 sho	piet	Disease, D.	labetes mel	litus					24a. Was		24b. Were au	topsy findings available completion of cause of	
	The ate ha	Completed								auto perfo	ormed?	death?	2/2 No	
Vital Records,	Physician: The la r this certilicate has ral director, page 2	Be (25. Was case referred to medical examiner?					26	6. Place of D	eath (Check only	one)			_
5	Physi this c	၉	1 ☐ Yes 2 🗷 No	Hospital: 1 Unpatier		ER/Outpatient				Home 5□ Resi			cify)	_
UC C	Jing Atte tune	ion	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	м 2	8c. Injury at Work?	2 □No	28d. Describe	how inju	ry occurred		
Division of	tten deat stor: / the	licat	2 Accident investigation 3 Suicide 6 Could not be		rv - At ho	me farm stre			2 🗆 140	28f Location /	Street an	d Number or Ri	ıral Route Number,	_
2	r te	Certification;	4 Homicide determined	building, etc	. (Specify	1)	, , , , , ,	, onlog		City or To	wn, State)	Tarriogio riombor,	
	To the Hospital of within 24 hours et To the Funerel D completely filled in		29a. Certifier 1 Certifying Ph	ysician: To the best of	f my kno	wledge, death	occurred	at the time,	date and pla	ce, and due to the	cause(s)	and manner as	stated.	_
	he Ho in 24 he Fu pletely	Medical	(Check only 2 Medical Examone)	niner: On the basis of and manner star	examinat	tion and/or inv	estigation	, in my opina	on, death oc	curred at the time,	date and	d place, and due	to the cause(s)	
•	To t To t	Σ	29b. Signature and title of confider)			290	. License nu			29d. Da	te signed (Monti	h, Day, Year)	
,			THE CIT	the MD				11	9694			Jan 1	1,2006	
	(0		30. Name and address of person who	22 =				57	7		^			
242	-		31. Date filed (Month, Day, Year)	22, Sc 32, Registra	r's Signa	Gree	ene	Jr.	Batti	more, M	0 3	21201		
	Sta Registr			2006	الوات . الات الاسال	& A	SALL!	7						

		1 - State Amend Item 2 Registrar 1. Decedent's Name (First, Middle, Last,		- 06	entificate of i	Dealli	2. Date of Deat		3. Time of Death	
Physic /Med		Dennis Jose					Janiary 2	2,2006 Yea	12:55am _M	
Exam	iner	4a. Facility Name (If not institution, give 704 Briddle Wret			4b. City, Town, or Mount		ath	4c. County of De	eath	
Funera Directo		5. Social Security Number 6. Se 173–34–1721	7. Age M 2□F	(In yrs. last birthday 63 Yrs.	Months Days	If Under 24 Hi Hours Min		Year)	Birthplace (State or Foreign Country) niladelphia, PA	
Maryland a-f ahow	tor	10a. State 10b. County PA Philadel	phia	10c. City, Town or L	ocation iladelphia	a			10d. Inside City Limits 1 ▼Yes 2 □ No	
with the	Director	10e. Street and Number 823 Princeton Av	enije		10f. Zip Code 19111	· · · · · · · · · · · · · · · · · · ·	1	10g. Citizen of What Country? USA		
72 hours after death with the Maryland "neturel", or Items 23s or 28s-f show idical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ★Yes 2 N If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba	ispanic Origin?	(Specify Yes or No- orto Rican, etc.)			
within 72 ane. than "nel	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 1.2		+) (Give	edent's Usual Occup e kind of work done o DO NOT use retired Cavel Ager	during most of w d) CY	orking	16b. Kind of Busine Travel 1	•	
should be fill and Menta! H marked ott umatic even	To Be	17. Father's Name (First, Middle, Last) Robert Weis					_{ame (First, Middle, M} y Catheri		Į.	
alth a		19a. Informant's Name/Relationship (7) Stacy Westbrook /			Briddle W		Rural Route Number, Ly Mount A	irey,MD 2	1771	
Pages 1 nent of H int: If ite		20a. Method of Disposition 1 Burial 2 Cremation 3 14 4 Donation 5 Other (Specify)		cemetery, cre	osition (Name of omatory or other place Crematory			Bensalem,		
permit. Pages 1 a Department of He Important: If item any injury or othe	K	21. Signature of Funeral Service Licens	98		22. Name and Addres Charles L	ss of Facility Stevens	Funeral Hom Baltimore	e Inc.		
Physician /Medica Examine		23a. Part1. Enter the disease, or compleshook, or heart failure. List of the limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or as a	consequence of):	nter the mode of dyin	g, such as cardi	ac or respiratory arre	est,	Approximate Interval Between Onset and Death	
cate be executed physicien and the burial-transit	dical Examine	if any, leading to immediate cause. Enter Underlying Cause (Lisease or min') that initiated events resulting in death) Last	c	consequence of):						
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3:	□Ectopic pregnancy □ Other (specify)			23d. Date of o Month	delivery Day Year	
w requires that been signed to should be det	by	Part II. Other significant conditions co	ntributing to death but	t not resulting in the	underlying cause give	en in Part I.			to the cause of death? Probably 4 Aunknown	
	e Completed	25. Was case referred to medical						prior t death No 1 Y		
hys his I dii	To B	examiner?	1 Inpatien 28a. Date of Injur (Month, Day	y 28b. Time (of 28c. Injury	er: 4 🗆 Nursing	Home 52 Reside	nce 6 Other (S)	Daughter' Residence	
Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ry - At home, farm, s . (Specily)	treet, factory, office	ory, office 28f. Location (Street and Number or Rural Route North City or Town, State)			Rural Route Number,	
s afte		29a. Certifier (Check only 2 Medical Exami	sician: To the best of	examination and/or ii	th occurred at the tim	ne, date and place	ce, and due to the ca curred at the time, da	use(s) and manner ite and place, and d	as stated. ue to the cause(s)	
ne Hospital or 24 hours afte ne Funeral Dir	dic	one)	and manner sta	180.						
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Medical	29b. Signature and title of certifier Balah Men	and manner sta	<u>Ø</u>	29c. License	a number		Od. Date signed (Mo		

			For State Registrar	State of Mai	ryland /	Department of Certificate	of Health and I	Mental Hygier	ZUUD	01142
	Physici /Medic	cal	- 11 - 0	nma	Wil	50 n	and another of Phone	2. Date of Death Month	Day Year Lo 2006	3. Time of Death
	Examir Funeral Director	ier	5. Social Security Number 6. Se	raer Av.	C. (In yrs. last bi	rthday) If Under 1	wn, or Location of Deat A LT MOLIF (Pear If Under 24 Hrs lays Hours Min.	8. Date of Birth		MORE Implace (State or Foreign untry) OINICA
	death with the Maryland me 23a or 28a-f show Entrible multied at	rector	10a. State 10b. County MD DACT M 10e. Street and Number	IOZE.	10c. City, Tov	n or Location A LTI 10f. Zip Co	MORE	10g.	Citizen of What Co	10d. Inside City Limits 1 Yes 2 No untry?
127 AN		Funeral Director	2701 Wildbe 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1 Pes 2 No If Yes, Give		13. Was Deceden If Yes, specify	21234 t of Hispanic Origin? (S Cuban, Mexican, Puerl	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White	ncan Indian, e, etc.
11 SON 11	ithin 72 hours after ne.	Completed by	3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)	year or Dates:	168	Decedent's Usual C (Give kind of work of life. DO NOT use f	Occupation done during most of woretired)	rking 16b	Specify: U	n/H.
Son	should be filed within and Mental Hygiene. I marked other than umatic event, the Mental Hygiene.	To Be Con	17. Father's Name (First, Middle, Last)	Le Gray	\ <u>/</u>	omema	18. Mother's Nar	me (First, Middle, Maid	en Sumame)	J .
HAry Wil	0 0		19 Informant's Name/Relationship (7 20a. Method of Disposition 1 Disposition 1 Disposition 1 Disposition 5 Other (Specify	Removal from State	20b. Place	o. Mailing Address (S of Disposition (Name only, crematory or other	treet and Number or Ri	TVO BACT	y or Town, State, 2	110 21234
MA	permit. Pege: Department of importent: If! eny Injury or once.		21. Signature of Funeral Service Licentary 22. Signature of Funeral Service Licentary 23a. Part 1. Enter the disease or a more	See Works that caused the	he death. Do	EVANSFI	Address of Facility P	ACTI MORE, AACT STOCK	MO 212 HARFOR	Approximate
•	Physician /Medical Examiner	ner	shock, or heart failure. List only of limediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	one cause on each ine	YO WAY consequence	y artery	1.			Interval Between Onset and Death
1/11/04	icate be executed physicien and sthe burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequence	of):				
3 2 0	ne deeth certif the ettending thed for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal deat	3 ⊟Ectopic pregr 5 □ Other (speci			23d. Date of del	ivery Day Year
9	w requires that the been signed by should be detact	þ	Part II. Other significant conditions on Dementi	ontributing to death but	not resulting	in the underlying caus	se given in Part I.	23e. Did tobacc		the cause of death?
	ion: The law rificate hes b stor, page 2 sl	Be Completed	25. Was case referred to medical		-		26. Place of De	24a. Was an autopsy performed 1 Yes 2 2 2	? prior to death?	atopsy findings available completion of cause of
7	ing Physic Mer this ce	ည	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospitat: 1 ☐ Inpatient 28a. Date of Injury (Month, Day		utpatient 3 DOA Time of 28c. Injury	Other: 4 Nursing H	Home 5 Describe how in		сіfу)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
(3)	the Hospi in 24 hou the Funer pietely fill	Medical	29a. Certifying Ph (Check only one)	ysician: To the best of niner: On the basis of e and manner state	examination a	nd/or investigation, in	my opinion, death occu	e, and due to the cause urred at the time, date	r(s) and manner as and place, and due	stated. to the cause(s)
	To To	2	29b. Signature and title of certifier	NO		29c. L	D2417		Date signed (Mont) UNUARY	1
	8		30. Name and address of person who RIC	ney Hospia	2 8	(Type, Print) 38 NEV	itan St 1	Baltimore	MD 2	1201
	Sta Regist	ate rar	31. Date filed (Month, Say, Yeàr)	32. Registrar	's Signature	Carrier .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle Year Physician 16,2006 0117 /Medical 4b. City, Town, or Location of Death c. County of Death Examiner 7. Age (In yrs last birthday, Date of Birth (Month, Day 5. Social Security Number Birthplace (State or Foreign
 Country) **Funeral** Days Hours Min 242-29-0801 Usual Residence of Decedent 1 MM 2□ F Yrs. Director 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1213 Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Int: If Itam 27 is marked other than "natural", or Items 23 10 12. Was Detedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Never Married 2☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2000 Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) dary (0-12) s Name (First, Middle, Last) 48 Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 is any injury or other trau once. Mother Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signal, e of Funeral Service Licensee NOV 3000 % BultoMD 23a. Pairl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hean failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiomyopathu Immediate Cause (Final Physician years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner > 30 years ongenital Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tibrillation atrial 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? sleep aprica 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 PER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner-of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35199 18/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 830 E. Monument St. Rm 8068 13055, MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

JAN 2 0 2006

32. Registrar's Signature

ORIGINAL

		_	State Registrar	Otate of Mic			rtificate of L		Re	Are Legible. iene 0 0 6	01145	
	Physicia		1. Decedent's Name (First, Middle, Last) Joseph A. Willia	ams					2. Date of Death Month January	09,2006 ^{Year}	3. Time of Death 19:36 P M	
		/Medical Examiner 4a. Fecility Name (If not institution, give street and number)					4b. City, Town, or		<u> </u>	4c. County of Death		
	×	725 Glenwood Street 5. Social Security Number 6. Sex 7. Age (In yrs.				rthday)	Annapolis	If Under 24 Hrs.	8. Date of Birth	Anne Aru		
	Funeral Director		213-34-5426	M 2□F	69		Months Days	Hours Min.	Jan 6	Year) 1937 Ma	rthplace (State or Foreign Country) ryland	
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	ocation				10d. Inside City Limits	
	Sa-1 of	Director	Maryland Anne Aru	nde1	Anna	001					XYes 2 □ No	
	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. Hygiene. do ther than 'naturel', or tems 23a or 28a-f ehow event, the Madical Examiner must be notified at	al Dir	725 Glenwood St.				10f. Zip Code	401	10	og. Citizen of What C USA	ountry?	
	ltems 2	Funeral		2. Was Decedent I Armed Forces?		13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp. n. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh		
2-003p	ours aft	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced	1 ☐ Yes 210 N If Yes, Give Year or Dates:	NO		1⊡Yes 2⊡XNo	Specify:		Specify:	Black	
ا ت	n 72 ho "natur	Completed	15. Decedent's Educ (Specify only highest grade	completed)	16a	. Dece (Give life.	dent's Usual Occupa kind of work done d DO NOT use retired	ition luring most of work	ing	16b. Kind of Business	s/Industry	
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Maryland 2121		Be	17. Father's Name (First, Middle, Last) George Williams					18. Mother's Name Martha		faiden Sumame)		
ary	s 1 and 2 should be f Heelth and Mental item 27 is marked o other treumatic eve	^c	19a. Informant's Name/Relationship (Typ				-			City or Town, State,		
as a	s 1 and if Heelth item 27 other tr		Joan Mobley(Frie				ISIANG C psition (Name of paton/portion/ag			polis, Mo 20c. Location - City o		
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Balt	permit. Pages 1 Department of H Important: If ite eny injury or oti once.		21. Signature of Funeral Service License		,	W	m ^{Name} Reese	s of £acilyons	Mortua	ary, P.A		
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Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be exe thin 24 hours ster death. The this certificate has been signed by the attending physicien at To the Funeral Director. After this certificate has been signed by the attending physicien at completely filled in by the funeral director, page 2 should be detached for use as the burial-to	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome	2 Fetal deat		Ectopic pregnancy			23d. Date of de	olivery Day Year	
<u>.</u>	that the death ted by the atter detached for t	hysic	1 Yes 2 No 9 Unknown	4☐ Pregnant at 9☐ Unknown	time of death	51	Other (specify)					
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o t	g Phy: ter this neral di	n: To	17 Yes 2 No 27. Manner of Death	28a. Date of Inju	ont 2□ER/O ry Fnd 28b. v Year)		f Fnd 28c. Injury	at Inc.	28d. Describe ho	nce 6 X Other (Sp. w injury occurred	ecity) SCEIIE	
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Σ	al or Al s efter o il Dirac id in by	Certification:	4 Homicide determined	77	ury - At nome, r c. <i>(Specify)</i> nd Reside		reet, factory, office		City or Town	reet and Number or F ^{1, State)} 725 Glet MD	nwood Street	
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	ro the within 2 Fo the comple	Med	29b. Signature and the operation	and manner sta	A. A. A. A. A. A. A. A. A. A. A. A. A. A	1	29c. License			9d. Date signed (Mor		
6	<		HILL	ANS	IV	-	O.C.M	.E.	Ja	anuary 10,	2006	
0	0		30. Name and address of person who con				· _	, Baltimo	ore, Mar	yland 2120)1	
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 0 2006	32. Registr	111	e obs	?,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 006 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** January 13, 2006A M Virginia Kemp Wicklein 7:45 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Timonium

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Yeer) Baltimore Stella Maris Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X** F 218-07-3293 85 January13,1920 Maryland Director Usual Residence of Decedent 10c. City, Town or Location I.Od. Inside City Limits 10a, State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygene. Best if the man 21s and extend the result. It files 21s a or 28a-f show ury or other traumatic event, the Madical Expribited, ast two notified as 1 ☐ Yes 2 No Director Marvland Baltimore Towson 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 212 Aigburth Road #114 21286 United States Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Frederick Owen Kemp Elsie Mae Teat Dtr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Susan V. Wicklein Sanders 83 Collins Drive, Martinsburg, WV 25401 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
eny injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 5x Other (Specify Entombment Lorraine Park Cemetery Jan. 17, 2005 Baltimore, Maryland Fun al Service Licensee 22 Name and Address of Facility Brian T. Chisholm Funeral Services of Dulaney Valley, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Heret Congritive Immediate Cause (Final 411 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): nding physician a 68760. certificate be Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) P.O. 1 the à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Comminy 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?

Division of Vital Records, Hospital or Attending Physicien: After within 24 hours after death. To the Funerel Director: A

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 137882

Carta Da

State Registrar

Be

Certification:

Medical

31. Date filed (Month, Day, Year)

Rohart



			1 - State Regis Am end Item #12					d Mental Hyg		6 01146
4,	· *		Decedent's Name (First, Middle, Last)	JIJJIUAUL	10022	Tel Tir G	391°1/2	2. Date of Dea	th	3. Time of Death
die .	Physici /Medic	_	Joseph A. Walker					January	Day \	11:46 PM
	Examin	100	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of D		4c. County of	
			Prince George's M 5. Social Security Number 6. Sex		nter (In yrs. last birthday)	Chever1	y If Under 24 I	Hrs. 8. Date of Birth	Prince	Georges
5	, Funeral Director			M 2□F	45 Yrs.	Months Days		Min. (Month, Day	, Year)	9. Birthplace (State or Foreign Country) unk
v	D		Usual Residence of Decedent					110 20,	1700	
	arylar show	_	MD 10b. County Prince Ge	amaa ta	10c. City, Town or L		_			10d. Inside City Limits 1 ☐ Yes 2√ No
	the M	ecto	10e. Street and Number	eorge s	Capit	ol Height	S		l 0g. Citizen of Wh	21
	3a or	ומו	319 Meadow Way			101. Zip 0000	20743		US	•
	within 72 hours after death with the Maryland ene. than "neturel", or llems 23a or 28a-f show ta Medical Exercitar mast be notified at	Funeral Director		2. Was Decedent E	ver in U.S. 13.	Was Decedent of Hi		? (Specify Yes or No- uerto Rican, etc.)		American Indian,
9	or Its	, Fu	1 X Never Married 2 ☐ Married	Armed Forces? XX Yes 2514	0	1 ☐ Yes 21 No	Specify:	ueno nican, etc.)		White, etc. black
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b	al Hyg	Вес	17. Father's Name (First, Middle, Last)			unk		Name (First, Middle,		
<u>ya</u>	Ment Ment Marked	2	Luther A. Kabi					oerta Brow	_	
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, It a Medical Examinat mast be notified at		19a. Informant's Name/Relationship (Ty)	•				r Rural Route Number		_
ē,	1 and Healt Iem 2	0	Prince George's Me 20a. Method of Disposition	icai cen	20b. Place of Disp	sition (Name of	-	Cheverly,	MD 2074 20c. Location - C	
Baltimore,	Par Par Par Par Par Par Par Par Par Par		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	im state		matory or other place	1			
Bal	permit. Departr Imports any inj		21. Signature of Euneral Sprice License	1 Helec	Ba	altimore,	MD $\frac{21}{21}$	20 1 5151	Balto. 1	ral _s Service Nat.
· ·			23a. Part 1. Enter the disease, or complishock, or heart failure. List only on	ations that caused e cause on each lin	the death. Do not en	1 0	1// .)	est,	Approximate - Interval Between
10	Physician		Immediate Cause (Final disease or condition resulting in death)	Jane	Cardea	c Arrh	y the me	W		Onset and Death
	/Medical Examiner		()	Anahot	consequence of):	ites)			
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	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
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9	eath certific attending p	/Me	IF FEMALE:	3c. If yes, outcome of	of pregnancy				23d. Date	
Вох	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)			Month	
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ecc	has be	Completed						24a. Was a autops	sy pric	ere autopsy findings available or to completion of cause of
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Ž.	Physician: Th this certificate ral director, pag	Be c	25. Was case referred to medical examiner?	ospital:		ot 30 DOA Othe	25	Death (Check only or		
ō	Physic Properties	7: To	1 ☐ Yes 2 🕅 No	1 Inpatier 28a. Date of Injur	y 28b. Time o	11 30 DOX	4 🗀 14013111	ng Home 5 ☐ Reside	ence 6 UOther ow injury occurred	
ion	utending death. ctor: Alte y the fune	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injury		(? Yes 2 □ No			
Division of Vital Records,	or Attending after death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ry - At home, farm, st	reet, factory, office		28f. Location (Si City or Town		or Rural Route Number,
	ital or A									
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	29a. Certifier (Check only one) 2 Medical Examination	ician: To the best of er: On the basis of and manner sta	examination and/or in	h occurred at the tim evestigation, in my op	ne, date and ploinion, death o	lace, and due to the coccurred at the time, d	ause(s) and mann ate and place, an	ner as stated. d due to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	1 Feg,	0	29c. License	0286	5	9d. Date signed (Month, Day, Year)
			30. Name and address of person who co	moleted cause of de	ath (Item 23a) (Type	Print)	2.	wie n	- 1	70727
	Sta	ite_	31. Date filed (Month, Day, Year)	32. Registra	r's Signature		100	ww p	ive a	0100
The state of	Registi		JAN 2 0 20	05	w D. A.	Bull				
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DHMH 17 Rev 1/2001

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Amend item 5 per fh 9852 2-7-06 vt
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 30 LEVESTER WADDY JANUARY 17 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE GWYNN OAK 6601 DALTON DRIVE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Nu4776 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X**M 2□ F 85 Yrs. 231-32-4778 03/29/1920 VIRGINIA Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28s-1 show other traumetic event, the Madical Examiner must be notified at GWYNN OAK BALTIMORE MD 1 Yes 2 No Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21207 6601 DALTON DRIVE death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? or itams 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: ģ 3 ₩idowed 4 Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) 12TH College (1-4or 5+) MINISTER CLERGY 6 YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) rmit. Pages 1 and 2 should be file partment of Health and Mental Hyportant: If itam 27 is marked oth y Injury or other traumetic event Be COLEMAN MARIE WATSON WADDY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6601 DALTON DRIVE, BALTIMORE, MD 21207 19a. Informant's Name/Relationship (Type, Print) WILLIE SCOTT / COUSIN 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)
KING MEMORIAL PK 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: if eny injury or once. 01/21/06 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 23a. First Enter the clease, or complications that caused the death spock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ğ Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | be detached 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by 4 Dunknown icate has been sig , page 2 should b 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗔 🕨 25. Was case referred to medical funeral director, 26. Place of Death (Check only one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes/ 2 10 1 🗌 Inpatient 2 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 | Homicide .⊆ pellil within 24 hours a to cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title at certifier 29c. License numbe in of death (Item 23a (Type, Print) 30. Name and address of person

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31. Date filed (Month, Day, Year)

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			1 - For State Registrar			land / D		nt of H	lealth and M Death	-	_	6	01148
	Physici /Medi		Decedent's Name (First, Middle Louise Evelyn Wi	lliams						2. Date of De Month JAN	Day	Year 206	3. Time of Death 18-14 PM
	Examir	ner	4a. Facility Name (If not institution SAINT AGI	VES 14	OSPIT		B	ALT	r Location of Death		4c. County	of Death	
	Funeral Director		5. Social Security Number 220-36-2215 Usual Residence of Decedent	6. Səx 1□ M 2X F	7. Age (In	yrs. last birth	Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 01-27-19	ly, Year)	9. Birthi Coul Maryl	place (State or Foreign ntry) and
	Maryland a-f show	ctor	10a. State 10b. County	NA	100	c. City, Town	or Location Balti	more	-				10d. Inside City Limits 1 X Yes 2 No
	3 or 28	i Direc	10e. Street and Number 3509 Springdale	Avenue			10f. Zi	Code	216		10g. Citizen of V		ntry?
0036	tiled within 72 hours after death with the Maryland Hygiene. Hygiene, then "naturel", or items 23s or 28s-f show not, it a Marical Examinat must be notified at	d by Funeral Director	11. Marital Status 1 Never Married 2 Mar. 3 Widowed 4 Divorced	12. Was Dec Armed For 1Yes	orces? 2 [X No ve	in U.S.	13. Was Dece If Yes, spe	dent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Rac	e - Americk, White,	
Maryland 21215-0036	be filed within 72 hours ital Hygiene. d other then "naturel", event, ira Mezical Exe	Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12) 12	t's Education st grade completed) College (1-4or 5+)		Decedent's Usu 'Give kind of wo life. DO NOT u	al Occupant done of se retired	ation during most of work i)	ang	16b. Kind of B		dustry ervices
yland	nd 2 should be filed within lith and Mental Hygiene. 27 is marked other then " rtraumatic event, I'm Mar	To Be C	17. Father's Name (First, Middle, Mack Farmer	Last)					18. Mother's Nam	e (First, Middle, Lee Colfi	Maiden Suman		ervices
ore, Mary	a 9 E 2		Deanna Bryant/ Date 20a. Method of Disposition 1XXBurial 2 ☐ Cremation	ghter		Ob. Place of I		n Mead	and Number or Rui dow Pkwy Ap			21209	
Baltimore,	permit. Pages I Depertment of H Important: If ite eny injury or ot ance.		4 ☐ Donation 5 ☐ Other (S	pecity)	V		Star Cem	nd Addres	01-25- ss of Facility Home 638 N		Catonsvi		
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W 12 CI A M P.O. Box 68760,	that the death certificete ed by the attending phys detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregr 9☐ Unkn	ointh 2 ☐ f nant at time own	Fetat death of death	3 Ectopic pi 5 Other (sp	ecity)	an in Part I	23a Did to	Moi		Day Year
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ال Division of V	fing Phys	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Maturat 5 Pendin investig Accident investig 3 Suicide 6 Could a determ	g 28a. Date (Mon. attorned)	of Injury th, Day Yea	At home, farm	ne of 2	8c. Injury Work	er: 4 □ Nursing Ho at ?? fes 2 □ No	me 5 Resid	lence 6 Other	ed .	
۵	Hospital 4 hours a Funeral i fely filled	Medicai Ce	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the Examiner: On the b	best of my asis of exam	knowledge,	death occurred or investigation	at the tim	e, date and place, pinion, death occurr	and due to the		nner as st	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		LESIDE	Nī	290	: License	number 1760+		29d. Date signed		Day, Year)
	2		30. Name and address of person KOLLT R	who completed caus	e of death ((Item 23a) (T	ype, Print) ATO N		BALT	MORE	, MD	212	28
	Sta Registr		31. Date filed (Month, Day, Year)	0 2006 32. R	entstrar's Si	ignature	Sperti	,					

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06-01 RKD		T TT T	CONT	Amend Univer	se T	ype or Prin	t in E	Black Indelib f,penME,g853 id / Departme	le Ink E	nsure A	Ali Copi	ies Are	Legible.	
	LANETTE		For			State of Ma	rylan				Mental	Hygien	9006	01149
			1 - State Registr	1:- 1:-	a (ast)	1 / Laneti	te Wi		te of De	airi	2. Date of	Reg. No	5.	3. Time of Death
	Physic		A H	-NEXF	, 220	Wilson	1	NillAN	3		JANU	_	y Year 2006	12:42P. M
	/Medi Examir		4a. Fecility	Name (If not institution	n, give s	treet and number)	-	4b. Ci	y, Town, or Loc	cation of Deat			County of pe	
5			MARYL		LН	OSPITAL	4		ALTIMOR er 1 Year If	E Under 24 Hrs.	0.0-4-	4 Diah	14	A 12 101 5 1
8	Funeral Director		5. Social Se	O- Number	1,50× 1□	M 22F	go yrs.	Yrs. If Unc		lours Min.		n Day, Year	1 M	
9			Usual Resid	lence of Decedent	-		10.0			1				104 Jacida Challista
	larylar ahow	or	10a. Stafe	10b. County	lΑ		100.00	Town or Location	PF					10d. Inside City Limits 1 res 2 \(\text{No} \)
	36 after death with the Maryla or items 23a or 28a-1 aho	Director	10e. Street	and Number		<u> </u>	P	101.	Lip Code	,		10g. C	itizen of What C	Country?
	th with	a Di	580	& ARiz	DIVA	AVE.		Ó	2/X06	0		U	5,A.	
	tems	Funeral	11. Marital S			12. Was Decedent E Armed Forces?		.S. 13. Was Dec	edent of Hispanecify Cuban, M	nic Origin? (S lexican, Puerl	Specify Yes o to Rican, etc	or No-	14. Race - Am Black, Wh	
	36 irs afte	by F		rer Married 2 Mar lowed 4 Divorced		1 ☐ Yes 2 Ø N If Yes, Give Year or Dates:	0	1 ☐ Yes	21 No S	pecity:			Specify:	3/ <i>PC</i> (
	5-00			15. Deceden	nt's Educ	cation completed):		16a. Decedent's U	ual Occupation	n na mostiof wo	rkina	16b)	(ind of Busines	s/Industry
	d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Hygiene "naturel", or Items 23s or 28s-1 show put, the Medical Examinar rount he notified at	Completed	Elementa	y Secondary (0-12)	Ĭ	College 14 or 5	+)	life. DO NOT	JE 4	AiNF		N	140 1916	
	ind 2.		17. Father's	Name (First, Middler,	(Last)	- ///		1001/4	18.	Mother's Nar	me (First, Mi	iddle. Maidei	Sumame)	
	# 9 to 5 do	To Be	iye	VIN W	nit	た		_		Sn	e//y .	JONE	55	
	Maryla d 2 should it th and Men 7 te marke	ĺ	1 a Inform	ant's Name/Relations	hip Ty	PAGE (4,4	pp	19b. Mailing Addre	ss (Street and	Number or Au	ural Sol to N	unger City	or Town, State.	Zip Coo)
	⊆ = ™ ≥		20a, Method	d of Disposition	11117	1110 (000	20b. P	Place of Disposition (A	ame of	ודן דונ	Date	2004	ocation - City o	Town, State
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	프 글등등을			e of Funeral Service		* Organi	ا م	22. Name	and Address of	Eacility	BEAR	162	Nucle	SIXTHON
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					r compli only or	cations that caused te cause on each line	the deat e.	h. Do not enter the m	ode of dying, st	uch as cardiad	c or respirato	ory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or resulting in		₽	Narcotic 1								
	Examiner		0	. Can an distant	1	0 00 10 (01 20 2		33.33 3.7.						
	D ≅	aminer	cause. Ent	y list conditions, ing to inmediate er Underlying ease or injury	Į	Dua to (or as a	consec	uance of):						
	xecuted and al-transit	Exam	that initiated	d events death) Last	c	Due to (or as a	conseq	uence of):			-			
	Box 68760, leath certificate be exec ettending physicien an I for use as the burial-tr	calE												
	68 rtificat ng phy as th	Physician/Medical	IF FEMALE		_									
	Box 6 eath certifi	lan/	23b. Was d	lecedent pregnant past 12 months?	2	3c. If yes, outcome of 1 ☐ Live birth 2	2 ☐ Feta	I death 3 Ectopic					23d. Date of de Month	elivery Day Year
	P.O. I	ysic	1 📮 Ye	es 2⊡No nknown		4□Pregnant at t 9□ Unknown	ime or a	eath 5 Other	specify)					
	IS, P.	by Pr	Part II. Othe	r significant conditi	ons con	tributing to death bu	t not res	ulting in the underlyin	cause given in	Part I.	23e. l	Did tobacco	use contribute	to the cause of death?
	Cords * require been sig											1 ☐ Yes 2	□No 3□F	Probably 4 Unknown
	e law r	ompleted										Was an autopsy performed?	24b. Were a prior to death?	autopsy findings available completion of cause of
	Vital Resident The Certificate har rector, page	O									1/20Y	es 2□No	1/00 e	s 2 No
	f Vit ysiclar is certii directo	o Be	examine	se referred to medica er? s 2 \(\) No		lospital:	nt 2 🔯	ER/Outpatient 3	Other	. Place of Dea			6 □Other (Sp	ecify)
	Physical distribution	-	27. Manner	of Death	: -	28a. Date of Injury (Month, Day	, 1	28b. Time of Injury	28c. Injury at Work?			ribe how inju		
	Sior eath. or: Af	catic	1 □Nat	cident investi	gation	Fnd 1/4/200	6	unk M	1 Tes	2 🛣 No	unk			
	Division of Vital Records, I or Attending Physician: The law requires thater death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification:	3 ☐ Sui 4 ☐ Ho	data	nined			ome, farm, street, fact y)	ory, office		City o	r Town, State	®)Retreat	and W. North
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exemithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physicien at completely filled in by the funeral director, page 2 should be deteched for use as the buriar-i		29a. Certific		ng Phys	horse stat	f my kno	wledge, death occurr	ed at the time, d	late and place	e, and due to	the cause(s) and manner a	as stated.
2	the Hc in 24 t the Fu pletely	Medical	(Check one)			ner: On the basis of and manner stat	examina ed.	tion and/or investigati			urred at the ti			
	To t To t	Σ	29b. Signat	ure and title of certifie	1	y 1 -1		2	9c. License nu				ite signed (Mor	
	•		30 Na==	keden 1	1	mnleted in a f	ath (lta-	n 23a) (Tunn Brint)	O.C.M	1.E.		JANU	IARY 5,	2006
				nd address of person	tine	10 וס יייור הסיפוליייי	au (iten		PENN S	STREET	BALTI	MORE M	IARYLANI	21201
ĺ		ate		ed (Month, Day, Year)	/	22. Registra	r's Signa	iture						
	Regist	rar		JAN 2 0 20	106	Alson	A C	Morrely &						

DHMH 17 Rev 1/2001

ORIGINAL

			1- State of Maryland /		ment of H icate of L		-	giene neg. No. 006	01150
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Joseph W Ei	mne	le-		2. Date of Dea Month	Day / Year	3. Time of Death 5.45 PM
	Examir		4a. Facility Name (If not institution, give street and number) HARFORD GARDENS	4b	. City, Town, or	Location of Death BALTIMOR		4c. County of De	ath N/A
	Funeral Director		5. Social Security Number 6. Sex 113-03-8427 1. Sex 1. M 2□F 94		Under 1 Year onths Days	If Under 24 Hrs. Hours Min.	B. Date of Birth (Month, Day OCT.2,1	9. B	irthplace (State or Foreign Country)
	yland now		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location	on				10d. Inside City Limits
	ith the Maryiar or 28e-f show se notified at	Director		BALTIM	ORE				1 VYes 2 □ No
	with the		10e. Street and Number	1	Of. Zip Code	21215	1	10g. Citizen of What C	
	death ms 23	Funerai	3601 FORDS LANE #703 11. Marital Status 12. Was Decedent Ever in U.S.	14. Race - Arr Black, Wh					
036	s 1 and 2 should be tiled within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other then "neturel", or items 23e or 28e-f show other treumatic event, the Mudical Examinat must be notified at	b	1 ☐ Never Married 2 ☐ Married I M Yes 2 ☐ No If Yes, Give Year or Dates:	Black, Wh	ite, etc. WHITE				
15-0	n 72 ho	ietec	15. Decedent's Education (Specify only highest grade completed)	(Give kind	s Usual Occupa of work done of	luring most of working	,	16b. Kind of Busines	s/Industry
21215-0036	tiled withir Hygiene. rther then ant, the M	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	CHEF	VOT use retired,) 		MERCHANT N	MARINE
Maryland	ould be tited Mental Hygid arked other atic event, I	Be	17. Father's Name (First, Middle, Last) SAMUEL	WEINRE	R	18. Mother's Name (First, Middle, i	Maiden Sumame)	KLEIN
aryl	should land Menis marke	٩					Route Number	r, City or Town, State,	
	1 and 2 Health a lem 27 is							TIMORE, MI	
Baltimore,	0 0	1	1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	-	ry or other place	1		20c. Location - City o	
altin	교론분들.		`4 □ Donation 5 □ Other (Specify) MD V		Me and Addres	ERY 01/19/	5 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	ON & BROS.	S MILLS, MD
Ä	Department of the contract of		Mant			ERSTOWN RO	DAD - P	IKESVILLE.	
ı	ur -u car		23a. Part1. Enter the disaste, or complications that caused the death. D shock, or beart failers. List only one cause on each line. Immediate Cause (Final	o not enter th	e mode of dying	-		9 0	Approximate Interval Between Onset and Death
	Enysician /Medical		disease or ndition resulting in leath) Due to (or as a consequence)	ce of):	auta	1 (0)	elige	adig	Wasthan
	Examiner	L	Sequentially list conditions. b. Corbnary	1 As	lery	disec	rse		lone to with
	uted J nosit	Examine	if any, leading to immediate ususe. Enter underlying Cause (Disease or injury	ce of):	100	1,200	390		
, 0,	be executed sician and burial-transit		that initiated events resulting in death) Last c. Due to (or as a consequence	ce of):	wo C	wor	OW.		
09289	ficate b physic s the b	edicai	d						
.O. Box (The law requires that the death certificate be executed ate has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown	ath 3□Ecto	opic pregnancy ner (specify)			23d. Date of de Month	olivery Day Year
0	quires that in signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting	g in the under	lying cause give	n in Part I.			to the cause of death? Probably 4 Unknown
l Records,		Completed					24a. Was a autops perform	y prior to	
Vital	Physicien: The rath is certificate ral director, pag	Be	25. Was case referred to medical examiner?		Othe	26. Place of Death (/
of		n: To	27 Manner of eath 28a. Date of Injury 28b	b. Time of	DOA 28c. Injury Work	4 W Nursing Home		ence 6 Other (Special Communication of the Communic	ecify)
sion	Attending I death. ctor: Atter y the tuner	atio	Month, Day Year) Z Accident investigation (Month, Day Year)	Injury N	Work u 1 □ Y	? ′es 2 □ No			
Division	tel or Attend rs after death ef Director: , ed in by the t	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	, farm, street, f	factory, office	28	f. Location (St. City or Town	reet and Number or F n, State)	lural Route Number,
217	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Atte completely filled in by the tune	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled 2 Medicel Examiner: On the basis of examination and manner stated.	ige, death occ and/or investig	curred at the tim gation, in my op	e, date and place, an inion, death occurred	d due to the ca at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier Such Tuplede	un"	29c. License	30661	7	9d. Date signed (Mon	16th 2006
			30. Name and address of person who completed cause of death (Item 28a 300 / X0 ch ROV M PAVA	, 13	allin	esto, 9	cd-	21239	7
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 0 2006 32. Registrar's Signature	Sperk	1				

			1- For State of Maryland / De C	partment of Health and ertificate of Death		01151
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last) Samuel Earl Abrams, Sr. 4a. Facility Name (If not institution, give street and number) October Communication (If not institution) (If	4b. City, Town, or Location of Deal	TAMARY 4 200 th 4c. County of E	red
	Funeral Director		215-32-7351 1 M 2 F 70 Yrs Usual Residence of Decedent	Months Days Hours Min	8. Date of Birth (Month, Day, Year) 9. Sept. 27, 1935	Birthplace (State or Foreign Country) Maryland
	Maryland 9-f show	tor	10a. State 10b. County 10c. City, Town or Maryland Cecil	Location Port Deposit		10d. Inside City Limits 1 ☐ Yes 2 No
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "neturel; or Items 23e or 28e-1 show other treumetic event. The Marjost Examinating assistantified at	d by Funeral Director	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	10f. Zip Code 21904 3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 □ Yes 2 No Specify:	In 10g. Citizen of What U.S. Specify Yes or Noto Rican, etc.) 14. Race - A Black, W. Specify:	
215-0	within 72 h ene. then "netu	Completed	15. Decedent's Education (Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of wo DO NOT use retired)	16b. Kind of Busin Boilermakers	ess/Industry S Union Local 13
Maryland 21215-0036	be filed withintal Hygiene. ed other then event, the M	Be	Twelve Years 17. Father's Name (First, Middle, Last)	Boilermaker 18. Mother's Na	me (First, Middle, Maiden Sumame)	a, Pennsylvania
aryle	2 should be fi and Mental F Is marked of eumetic ever	ဥ		illing Address (Street and Number or R	Margaret Ward ural Route Number, City or Town, Sta	te, Zip Code)
	1 and 2 Health a tem 27 lg			Benjamin Park Driv	The second second	Maryland 21904
ore	Pages 1 an nent of Heal int: If item 2 iry or other		La Danai 2 Coloniation 3 Chambra non State	position (Name of rematory or other place)	Date 20c. Location - City	
Baltimore,	permit. Pages Department of Importent: If it any Injury or o		21. Signafure of Funeral Service Licensee	22. Name and Address of Facility Lee A. Patterson &	Son Funeral Home	sit, Maryland, P.A.
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	1 / ~	c or respiratory arrest.	Approximate Interval Between Onset and Death
O. Box 68760,	le death certificate be executed the attending physician and hed for use as the burial-transit	Physiclan/Medical Exa	d	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of Month	delivery Day Year
Δ.	law requires that the d as been signed by the 2 should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribu	te to the cause of death?
al Records,	The ate ha	Completed			24a. Was an autopsy performed? deat	
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes PNo Hospital: 1 Inpatient 2 ER/Outpai	- Other -	ath <i>(Check only one)</i> Home 5 Residence 6 Other (Pageif d
ion of	ding Ph n. After th funeral	-	27. Manner of Death 28a. Date of Injury 28b. Time 28b. Time 28c. Date of Injury of 28c. Injury at	28d. Describe how injury occurred	apecity)	
Division	를 를 들	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and Number of City or Town, State)	r Rural Route Number,
	To the Hospitel within 24 hours and the Funerel Completely filled	edical	29a. Certifler (Check only one) 29a. Certifler (Check only one) 2□ Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occurred.	e, and due to the cause(s) and manne urred at the time, date and place, and	r as stated. due to the cause(s)
1	To the within To the compl	Me	29b. Signature and title of pertifier	29c. License number	29d. Date signed (M	lonth, Day, Year)
	10		30. Name and address of person who completed cause of death (Item 23a) (Type 281 E. W.)	p. Print) St., Resin	y Sur MD 2	2194
	Sta Registi		30. Name and address of person who completed cause of death (flem 23a) (fly 28 (2.2.1)) 31. Date filed (Wonth, Day, Year) 32. Registrar's Signature			

DHMH 17 Rev 1/2001

	an	Decedent's Name (First, Middle, La		Dr. Ce			2. Date of Dea Month	ith Day	3. Time of Death
Medi	cal	Barbara June A 4a. Facility Name (If not institution, give	Adkins		4b. City, Town, o	or Location of De	January	4c. County of	006 03:02 A
amir	ner	Washington Coun		İ		rstown	oatii		ashington
eral			Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year Months Days		Hrs. 8. Date of Birtl		Birthplace (State or Foreig Country)
ctor		231-64-7333 Usual Residence of Decedent	1 M 462V	62 Yrs.			March 2	8,1943	Virginia
id i		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limit
Pilied	Director	Maryland Wash	ington	Hagei	rstown				1XX es 2 □ N
Examinational be notified at		10e. Street and Number			10f. Zip Code	04=40		10g. Citizen of W	•
THE STREET	Funeral	55 E. Washington	n ST.	Ever in U.S. 13	1	21740	(Specify Yes or No-		- American Indian,
		1 Never Married 2 Married	Armed Forces?	No			? (Specify Yes or No- uerto Rican, etc.)	Black	, White, etc.
	d by	3 ☐ Widowed 4 🖔 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify:	White
	Completed	15. Decedent's E (Specify only highest gr		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	during most of	working	16b. Kind of Bus	siness/Industry
216 M	dmo	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Nursing				Medical
	BeC	17. Father's Name (First, Middle, Last	t)		nurorng		Name (First, Middle,		
	70 E	Mack Dowell R	ichards				e Emmaje		
		19a. Informant's Name/Relationship					r Rural Route Numbe		
onier traumatic		Juanita Call - [20a. Method of Disposition	Daughter	20b. Place of Dispo	N. Artiza	n St.	Williamspo		land 21795 City or Town, State
=		1 ∑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Ponation 5 ☐ Other (Speci		cemetery, crei	matory or other plac	· 1			wn,Maryland
eny injury c poce.		21. rignature Funeral Servin Lee	.7				lome, P.A.	nagersio	
Suc		1 Deal a th	h				•	lliamspo	21795 rt,Maryland
		23a. Par 1. Enter the disease, or com shock, or heart failure. List only	nplications that caused y one cause on each lin	the death. Do not ent					Approximate Interval Between
an		Immediate Cause (Finat disease or condition	a Seb	sis					Onset and Death
al er		resulting in death)	Due to (or as	a consequence of);	11 15	1			
Gara.			(4)(10		110015	Bla III.	10		
	0	Sequentially list conditions if any, leading to immediate	b. Due to (or 💉	a consequence of):	HCout (a'c lur	re.	700	
1	amlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or	a consequence of): SHOL L	Heart "	earc l	on hemo a	liely, i.	,
	l Examiner	S number of the control of any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of): CLU Currently Currentl	Heart r	Lanc 1	on hemo co	liely, i.	1
	dlcal	that initiated events	b. Due to (or c. Due to (or as	a consequence of): L L a co sequence of):	Heart " not dise	Lare	ve on hems a	liely, i.	
	edical	resulting in death) Last	Due to (or as d. 23c. If yes, outcome	2 30 7, 433/100 31/.	Heart r	earc (on hemo a		
	edical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d. 23c. If yes, outcome	of pregnancy 2 ☐ Fetal death 3 ☐	HCGY t (" not disc		on hemo a		of delivery
	edical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d. 23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	of pregnancy 2 Fetal death 3 time of death 5	□Ectopic pregnancy □ Other (specify) _	,	on hems a	23d. Date	of delivery
	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d. 23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	of pregnancy 2 Fetal death 3 time of death 5	□Ectopic pregnancy □ Other (specify) _	,	23e. Did to	23d. Date Mont	of delivery th Day Year oute to the cause of death?
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9	Physici /Medi		Decedent's Name (First, Middle, Last) LILLIAN D		AARO	N		2. Date of Dea Month	th Day Yea 0 2 2000	
	Examir Funeral Director		4a. Facility Name (If not institution, give street and legismal Me 5. Social Security Number 6. Sex 213-12-1177	dical Ce	nter	4b. City, Town, or	Location of Dea Oury If Under 24 Hrs Hours Min	th 8. Date of Birth	4c. County of Di	eath
-/	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	8e-f eh	Director	MARYLAND WORCESTER	В	ERLIN					1 ☐ Yes 2X No
	an or 2		10e. Street and Number 1135 OCEAN PARKWAY			10f. Zip Code BERL	TM	1	Og. Citizen of What	Country?
920	72 hours after deeth with the Maryland 'naturet', or items 23a or 28e-f show dical Examinar must be notified at	by Funeral	11. Marital Status 12. Was D 1 Never Married 2 Married 1 Yes	ecedent Ever in U.S Forces? s 2 X No Give r Dates:				Specify Yes or No- rto Rican, etc.)	USA 14. Race - Al Black, W Specify:	nerican Indian, hite, etc. WHITE
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Baltimore,	Pages 1 an ment of Heel tent: if item 2 lury or other		20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	m State C6	emetery, cren	sition (Name of natory or other place OF DELMA			DELMAR, D	
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68760,	tificate be executed // Medical Examiner as the burial-transit as the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	as a conseque to (or a))).	ence of):	al I	and the said	reta	_	Approximate Interval Between Onset and Death
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Division of Vital Records,	Attending Physician: Thir death. ector: Atter this certificate by the funeral director, pag	tion: To Be			ER/Outpatien 28b. Time of Injury	28c. Injury Work	4 Nursing H		e) ence 6 Other (Sp ow injury occurred	necify)
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	To the within To the Complex	Me	29b. Signature and title of certific	M	D		13756		9d. Date signed (Mo	06
	10/1/2		30 Name and address of person who completed ca	use of death (Item	23a) (Туре, Е. Со			sbury "	n D . 213	-01
	Sta Registr		31. Date filed (Month, Day, Year) 32 JAN 0 5 2006	Registrar's Signati	ure	1 . W .				

213-13-1177

Lillian Qaron

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			1. Decedent's Name (First, Middle, Last)	_							te of Deat			3. Time of	Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Mark Dana Bosley Jan 2006 7:15a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Westminster
If Under 1 Year | If Under 24 Hrs. 1509 Amalfi Drive Carroll 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral 1**√2 M 2 □ F Months Days Hours Min 902-89-2820 Yrs. Director 54 08-11-1951 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits 27 is marked other then "naturel", or items 23a or 28e-1 shov treumatic event, the Maxilcal Examinar must be multified at 1 ☐ Yes 2 No Director MD Carroll Westminster 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "nature" any injury or other treumatic average. 10f. Zip Code 10g. Citizen of What Country? 1509 Amalfi Drive Funeral 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Forman-Equipment Oper. Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles P. Bosley 2 Mary L. Chew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
21157 19a. Informant's Name/Relationship (Type, Print) 1205 Old Westminster Pk., Westminster, MD Jill A. Cashman - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ` 4 □ Donation 5 □ Other (Specify) Pleasant Grove 01-04-06 Reisterstown, MD 22 Name and Address of Facility Eline Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Carcinoma Immediate Cause (Final Priysician floor disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death Day 5 Other (specify) P.O. ed by the a 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ None KHOWA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform certificate Division of Vital 2 No 1 Yes 2 No 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 ther (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After th funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number WSL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Warthinster, and 21157 555 S. CZHIPL ST Ja:out x. un.D Howard 31. Date filed (Month, Day, Year) 32. Registrar's Signature How to fresh Registrar

ORIGINAL

DHMH 17 Rev 1/2001

		•	FUI	partment of Health and N e <i>rtificate of Death</i>		ne 006 01156
1	Physici	an	1. Decedent's Name (First, Middle, Last) JANETTE WARDWELL	BURHANS	2. Date of Death Month January 4	Day Year 3. Time of Death 3:00 A. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	purious y	4c. County of Death
		-	Homewood at Crumland Farms	Frederick		Frederick
Ê	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 1 M 2 XF 93 Yrs.	Months Dave Hours Min	8. Date of Birth (Month, Day, Ye September	9. Birthplace (State or Foreign Country) 15,1912 Ohio
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or			10d. Inside City Limits
	faryla	ō				1 ☐ Yes 2 🛣 No
	28e-1	rect	Maryland Washington Willia	IMSport 10f. Zip Code	10g.	. Citizen of What Country?
	3s or	i Di	16505 Virginia Avenue	21795		U.S.A.
9	filed within 72 hours after death with the Maryland Hygiene. sther than "netural", or Items 23s or 28e-f show ent, the Medical Ezarni's critical by Incilited at	/ Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
8	72 hours "netural",	d by	3 ★ Widowed 4 Divorced Year or Dates:		100	White
-5	in 72 ho "netur	olete	15. Decedent's Education (Specify only highest grade completed) (Gift	cedent's Usual Occupation ive kind of work done during most of work a. DO NOT use retired)	ring	b. Kind of Business/Industry
212	d with giene. rr thar	Completed	Elementary/Secondary (U-12) College (1-4or 5+) .	lomemaker		Own Home
nd	be file ital Hyg id othe event,	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	den Sumame)
Maryland 21215-0036	s 1 and 2 should be filed within F Health and Mental Hygiene. Item 27 Is marked other than '	P	George Alexander Marti			Wardwell
Mar	d 2 sh h and 7 Is rr traur			ailing Address (Street and Number or Rur Box 76, New Marke		
<u>ق</u> ـ	Health Health tem 27		20a Method of Disposition 20b. Place of Dis	sposition (Name of		C. Location - City or Town, State
JOE L			1 Aburial 2 Cremation 3 Hemoval from State	rematory or other place) 11 Cemetery 01-07	z_ne Hac	gerstown, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the MeODE.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Andrew K. Coffman F		ome, Inc. gerstown, Md. 21740
	00 = 8 O		229 Part 1 Enter the disease or complication that caused the death. Do not	40 East Antietam St	treet, Hac	gerstown, Md. 21740
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one ocuse on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	>		Interval Between Onset and Death
68760,	ficate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
P.O. Box 68	Attending Physicien: The law requires that the death certificate be executed roath. Geath, sold or: After this certificate has been signed by the attending physician and ythe funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi		3∏Ectopic pregnancy 5∏ Other (specify)		23d. Date of delivery Month Day Year
	s that gned b	by P	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
ords	equire en sig ould b	ted t	(orang Artary 013 en	<u>.e</u>	1 ☐ Yes	2 No 3 Probably 4 Aunknown
Vital Records,	The law r cate has be page 2 sh	Completed	Hyper IIp, demia	,	24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
Vita	sician: Th certificate rector, pag	Be	25. Was case rilerred to medical examiner? Hospital: Hospital:	Other	th (Check only one)	
0	ding Phys h, After this funeral di	lon: To	27. Manner of Death 1	e of 28c. Injury at	ome 5 ☐ Residence 28d. Describe how	ee 6 □Other (Specify) injury occurred
Division	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:			28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	Hospite 24 hours Funeral etely filler	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, divided in the desired form of the pasts of examination and/o and manner stated.	aath occurred at the time, date and place, r investigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	29c. License number D 16428	29d.	Date signed (Month, Day, Year)
0	6H-K		30. Name and address of person the completed cause of death (Item 23a) (Ty. Casper E. Cline III 300 W.		Eredenio	k, Md. 21701
0	Sta	ate	31 Date filed (Month, Day, Year) 32 Registrar's Signature		TEUELIC	N, 110. E1/O1
	Regist		JAN 0 5 2006 January D.	Sperker		

known to physicians as Janette Burnans

		4	partment of Health and Nertificate of Death		ene , ko. 006 01157
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Walter Morris Berkov		2. Date of Death Month Jan.	5 2006 3. Time of Death 9:48 AM
Examin		4a. Facility Name (If not institution, give street and number) 18 Battersea Rd.	4b. City, Town, or Location of Death Ocean Pines		4c. County of Death Worcester
Funeral Director		5. Social Security Number 203-09-7650 6. Sex 1 X M 2 F 83 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 7 - 19 - 192	9. Birthplace (State or Foreign PA
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Manhal Hygiene. Department of Health and Menhal Hygiene in Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Dines 10f. Zip Code 21811 3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify: Bedent's Usual Occupation We kind of work done during most of work DO NOT use retired)	eerfy Yes or No-Rican, etc.)	10d. Inside City Limits 1 □ Yes 2√□ No g. Citizen of What Country? US 14. Race - American Indian, Black, White, etc. Specify: White Sb. Kind of Business/Industry
Id be filed ental Hygir ked othar ic evant, t	To Be Co	17. Father's Name (First, Middle, Last) Hyman Berkov	K Review Editor 18. Mother's Nam Marion 1	e (First, Middle, Ma	Newspaper aiden Surname)
1 and 2 shou Health and M am 27 is mar thaumati	_	Janet Berkov 18 E	iling Address (Street and Number or Rur Battersea Rd., Ocea	al Route Number, o	Md. 21811
it. Pages : rtment of h rtant: if its njury or ot		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Cape Her	nlopen Crem.	- F	rankford, DE
De mi Impo		Tacqueura F about Do not e	22. Name and Address of Facility The 108 William St.	Berlin,	Md.21811
Physician Medical Examiner biharcian and physician and sthe partial-transit sthe partial-transit	dical Examiner	shock, or heart friture. List only be cause on each free. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	MOTIC CARDIO	NASCULA	Interval Batween Onset and Death
the death certific	Physician/Me		□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
raician: The law requisions to sentificate has been director, page 2 should	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
ng Phy frer this	ation: To Be	25. Was case referred to medical examiner? 1	ent 3 DOA Other: 4 Nursing Ho of 28c. Injury at	h (Check only one) ome 5 Residen 28d. Describe how	ce 6 □Other (Specify) injury occurred
To the Hospital or Attendia within 24 hours after death. To the Funarel Director: A completely filled in by the fu	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		City or Town,	
To the Hospital within 24 hours a To tha Funaral completely filled	Medicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de (Check only one) Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, date	e and place, and due to the cause(s)
To vit	2	29b. Signature and tifle of certifier	29c. License number DH6Z57		I. Date signed (Month, Day, Year)
1, 15 Sta	te .	30. and address of person who completed cause of death (Item 23a) (Type Double Color		city Bu	D. BERLIN, WD 2181
Registr		31. Date filed (Month, Day, Year) JAN 0 6 2006 32. Jegistrar's Signature	Joseph Land		

DHMH 17 Rev 1/2001

		For State Registrar	ate of Maryland /	Department of Health and I Certificate of Death	Reg.		5 0115
Physici	an	1. Decedent's Name (First, Middle, Last) Daniel Edward I	Blair		2. Date of Death Month TAN	Day 2 Year	3. Time of Death
/Medi Examir	al	4a. Facility Name (If not institution, give stree		4b. City, Town, or Location of Deatl		4c. County of Deal	
Exami	iei V	WESTERN MARYLAND HOSPITAL		Hagerstown		Washingto	on
Funeral Director		5. Social Security Number 219-20-0370 6. Sex	7. Age (In yrs. last b	Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		1926	thplace (State or Forei buntry)
of show	tor	Usual Residence of Decedent 10a. State 10b. County MD Washingt		en or Location or Spring			10d. Inside City Limit
23e or 28a at be not	al Director	10e. Street and Number 10 Cumberland Sti	reet	10f. Zip Code 21722	10g.	Citizen of What Co	ountry?
s I and 2 should be filed within 72 flouts after beath with the marylating the hand Mental Hygiene. Item 27 is marked other then "naturel", or Items 23e or 28a-f ehow other traumatic event, the Macical Examinating to act	by Funeral	11. Marital Status 1 □ Never Married	Vas Decedent Ever in U.S. Immed Forces? Tyes 2 NoWWII Yes, Give Korean ear or Date Korean	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- lo Rican, etc.)	14. Race - Ame Black, Whit Specify. Whi	e. etc.
ene. then *natur	Completed	15. Decedent's Educatio (Specify only highest grade con Elementary/Secondary (0-12) 12th	n 168 npleted) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of world life. DO NOT use retired) SUPERVISOR	rking 16b	Kind of Business ailroad	
h and Mental Hygiene. 7 Is marked other then " reaumatic event, the Mar	To Be C	17. Father's Name (First, Middle, Last) George B. Blair	0	18. Mother's Nar Laura	me (First, Middle, Maid A. H. Drur	den Surname) Y	
Health and N Hem 27 Is mer other traumal		19a. Informant's Name/Relationship (Type, I Betty R. Blair		b. Mailing Address (Street and Number or Ru P.O.Box 115 Clear		ty or Town, State, 2 MD 2172	
nent of He int: If Item iry or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State Cedar	of Disposition (Name of ery, crematory or other place) Jan. Lawn Cemetery 2	7 ·	Location - City or gerstow	
Department of Important: If I any injury or once.		21. Signature of Funeral Service Licensee		22 Name and Address of Facility Donald Edwin Th P.O.Box 310 Clea	nompson F	uneral	Home
hysician /Medical		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	Congesty	onol enter the mode of dying, such as cardiac up Heart Fall	or respiratory arrest,		Approximate Interval Between Onset and Death
xaminer	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a)consequence	y disease			12×
g physicien and set the burial-transit	cal Examiner	cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence				101
the attendin	Physician/Medical	in the past 12 months?	yes, outcome of pregnancy □Live birth 2 □ Fetal deat □ Pregnant at time of death □ Unknown	h 3 Ectopic pregnancy 5 Other (specify)		23d. Date of de Month	livery Day Year
in signed by	þ	Part II. Dther significant conditions contribu	uting to death but not resulting	in the underlying cause given in Part I.			o the cause of death?
ine law re ate has bee page 2 sho	Completed			18.	24a. Was an autopsy performed	prior to death?	utopsy findings availa completion of cause of
certificate	Be	25. Was case referred to medical examiner?	tal:		ath (Check only one)		
ar this eral dii	n: To	1 165 252140	1 Inpatient 2 EH/C	Time of 28c. Injury at	forme 5 Residence		cify)
to the hospital of Authorny Priystoten, the within 24 hours after death. To the Funeral Director; After this certificate his completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 6 Could not be 2	Be. Place of Injury - At home,	M 1 Yes 2 No	28f. Location (Stree		ural Route Number,
one hospital of Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		4 Homicke	building, etc. (Specify) n: To the best of my knowledge	ge, death occurred at the time, date and place	City or Town, S		s stated.
ne Ho in 24 t he Fu pletely	edical	(Check only 2 Medical Exeminer:	On the basis of examination a and manner stated.	nd/or investigation, in my opinion, death occu	urred at the time, date	and place, and due	to the cause(s)
	Σ	29b. Signature and title of certifier		29c. License number 0 5 2 3 2 3	29d.	Date signed (Mont	h, Dey, Year)
1 v T V T V T V T V T V T V T V T V T V T						1/2/6	

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Year **Physician** 2000 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner -100× If Under 24 Hrs. Birthplece (State or Foreign
 Country)
 MT Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min December 28,1913 Days 559-20-4461 1 🕅 M 2 🗆 F 92 MT Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r then "natural", or itams 23a or 28a-f show the World Examiner was be notified at MD Queen Anne's Chestertown 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21620 USA 209 Creston Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. 11. Marital Status 1 TYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Completed by 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ie marked other then Elementary/Secondary (0-12) College (1-4or 5+) Union Representative Public Works 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy important: If Item 27 is marked oth any linury or other traumatic event once. Be Reginald Blanchard May Palmer 19a. Informant's Name/Relationship (Type, Print)
Linda Walmsley/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 710 Rosin Drive, Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other of Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Crumpton Cemetery 01/06/2006 Crumpton, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service I 22.Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 30 Speer Road, Chestertown, haryland 21020 23a. Part1. Enter the disease, or conformations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ArteroSclerotic Cardio Vascular Disease **Physician** Syears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any latent to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit led by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? no Discase 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 28 No 1 ☐ Yes 2 ☐ No 1 Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death
1. Natural
2 Accident s after death. 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation completely filled in by the 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D50996

State Registrar

5

Stodagurd

JAN 04

31. Date filed (Month, Day, Year)

hestertown, MD

who completed cause of death (Item 23a) (Type, Print) 100 Brown

32. Regisar's Signature

2006

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mentel Hygiene. Importent: If Item 27 is marked other then "natural; or Iteme 23s or 28s-1 ehow many injury or other traumatic event, the Medical Exprise trust be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Oi

_	1 - State Registrar					Ce	rtificat	e of L	Jealli			Reg. No	o	
1	Decedent's Name Ch			Bocha							. Date of De _Month	Da	y Yeer	
	4a. Fecility Name (II						4h Cihr	Town or	Location of		Janua		, 2006 County of Dea	3:18
		y Hous	_	street and ma	iino o r)			ckvil		Dealli		40		omery
	5. Social Security N		6. Sex	(]M 2□F	7. Age (In yrs.	**) If Under	r 1 Year Days	If Under 24 Hours	Hrs. g	. Date of Bi (Month, D	rth ay, Yea <i>r)</i>	0.8	irthplace (State or a
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Ì	10a. State	10b. Count	ty		10c. Ci	ty, Town or L	ocation					,		10d. Inside City
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by runeral Director	11. Marital Status1 ☐ Never Marri3 ☐ Widowed		beins	Armod E	orces? 2 □ No WW: ive		If Yes, spe		spanic Origin n, Mexican, I Specify:	Puerto Ri	can, etc.)	0-	14. Race - Am Black, Wh Specify:	
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3	17. Father's Name	/Eirst Middle	2 (act)			Muni	tions		ialis		Circle & Aintella			nt of Arı
0 20		eorge		nanis					18. Mother's	hali		avas	,	
-]	19a. Informant's Na	ame/Relation	nship (Ty	pe, Print)		19b. Mail	ing Address	s (Street au					or Town, State,	Zip Code)
	Mary Bock	hanis/	/ Wif	e		5924	Conwa	ay Ro	ad Be	thes	da. MI	208	317	
	20a. Method of Disp		3 🗆	lamoval from		Place of Disp cemetery, cre	osition (Na	me of	1	Dat			ocation - City o	or Town, State
H	4 Donation			emovar nom	Ar	lington				n.9,			ington,	
	21. Signature of Fu	in rai Servic	e Licens	Som	\mathcal{I}								s Sons 20016	, Inc.
	23a. Part1. Ener the shock, heat Immediate Cause (disease or condition resulting in death)	rtianure. Li: (Final	or compli st only or	Pr	caused the deal each line. neumonia (or as a consec	th. Do not en								Approximate Interval Betwee Onset and De
cal Examiner	Immediate Cause (disease or conditio	(Final in inditions, inditions, inditions, inditions inditions	or compliss only or	Due to	neumonia	th. Do not end a quence of): Debili quence of):	iter the mod							Interval Between
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				epartment of Health and M Certificate of Death	54	ene 0 0 6	01161
	Physici	.	1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
	/Medic		Edward Benjamin Brandhoff		January	8, 2006 ar	10:12 Р м
	Examin	er	4a. Facility Name (If not institution, give street and number) Laurelwood Nursing Home	4b. City, Town, or Location of Death Elkton		4c. County of Dea Cecil	
	E-mand.		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		8. Date of Birth	9 Rin	thplace (State or Foreign
	Funeral Director		No. 10 C	Months Days Hours Min.	Aug. 14,	rear C	ryland
	D		Usual Residence of Decedent				
	laryla ahov	5	MD Harford Aberdee				10d. Inside City Limits 1 XYes 2 No
	28a-f	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What C	
	death with the Maryland ms 23a or 28a-f ahow rmst Lynutified at	Ö	55 Mt. Royal Avenue	21001		U.S.A	•
		Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - Am	
S	or It	by Fu	1 Never Married 2 Married Wayes 2 No	1 ☐ Yes ŽXXNo Specify:	nour, etc.)	Black, Whi	
21212-0030	within 72 hours after ene. than "natural", or Ite	ed b	The second secon	Decedent's Usual Occupation	1 4		
Ċ	n "na Nedic	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	ng "	6b. Kind of Business	vindustry
7	d with giene ar tha	E O	Elementary/Secondary (0-12) College (1-4or 5+) Lau	ndry Superintendent	P	PVAMC	
/land	be file ta! Hy d othe	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		aiden Sumame)	
<u>X</u>	Meni Meni Marke Marke	2	Edward B.H. Brandhoff	Blanche			
Ma	permit. Pages 1 and 2 should be f Department of Health and Mental b Important: If item 27 Ia marked of any injury or other traumatic eve ange.		1	Mailing Address (Street and Number or Rural Mt. Royal Ave., Abe			Zip Code) 21001
ā,	tem 2		20a. Method of Disposition 20b. Place of Disposition	Disposition (Name of D		Oc. Location - City or	
Ē	Pages ent of nt: If i		I Courtai 2 Cremation 3 Chemoval from State 1	crematory or other place) Cemetery 1/12/	06 A	berdeen,	Maryland
Saitimor	permit. Departmimporta Importa any inju		21. Signature of Funeral Service Licensee	27 Name and Odress of Ficility Tuno			
<u>n</u>	8958	-	Kusten A. Une les bu	² Tarring-targo Func Aberdeen, Maryland			
		-	23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac or	r respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)				Onset and Death
	/Medical Examiner		Due to (or as a consequence of	f):			
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	f):			
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Ď.	e exectian an		resulting in death) Last Due to (or as a consequence of	f):			
2/60	icate be executed physician and s the burial-transit	dicai	d				
×	ding p	a a	IF FEMALE: 23c. If yes, outcome of pregnancy			1	
DOX	that the death certifued by the attending to detached for use as	Physician/M	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	Day Year
j.	t the d by the ached	hysi	1 Yes 2 No 9 Unknown				
ທົ	requires that een signed b nould be deta	by P	Part II. Other significant conditions contributing to death but not resulting in t	the underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ä	w require been sig should b	ted			1 ☐ Yes	2 □ No 3 □ P	robably 4 Unknown
Records,		ompieted			24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
	alcian: The law certificate has t irector, page 2 s	Co	11		performe	ed? death?	2 No
VII	Phyalcian: this certific ral director,	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death Other: 45 Dogs Horning Horning		1122	
ō	Phy this ral d	To :	1 ☐ Yes 2 ☐ No	patient 3 DOA PENUISING HOR	ne 5 Residen 8d. Describe how	ce 6 Other (Spe	cify)
0	nding Ph tth. r: After th e funeral	ation		jury Work? M 1 ☐ Yes 2 ☐ No		,,	
UNISION	Attencer death	Certification:	3 Suicide 6 old not be 4 Homicide 28e. Place of Injury - At home, fam building, etc. (Specify)	m, street, factory, office	8f. Location (Stre City or Town,	et and Number or Ri	ural Route Number,
5	ital or rs afte ral Dir led in	Cert	Sullulity, etc. (Specify)		City or Town,	States	
	Hospi 24 hou Funer fely fill	edical	29a. Certifier (Check only A 2 Medical Examiner: On the basis of examination and	death occurred at the time, date and place, a for investigation, in my opinion, death occurre	nd due to the cau	se(s) and manner as and place, and due	s stated. to the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Med	one) and manner stated. 29b. Signature and till of certifier	29c. License number		I. Date signed (Mont	
	F 3 F 8 €) /	D54073		1 Jan 06	
	AXI		30. Name and address of person who completed cause of death (Item 23a) (T			,	
	ופ		Accord State us 8170	cincennous con	L NO	VLATLE DE	19720
	Sta		31. Date filed (Month, Day, Year) JAN 1 8 2006 32. Registrar's Signature	radio			
	Registr	ar	TO COOL MANAGED TO THE	Part of the second seco			

			1- For State of Maryland / Department of Health a Certificate of Death		Hygiene 006	01162
	Physici		Decedent's Name (First, Middle, Last) TERESA BENNETT BROWN	2. Date of Month JANU	Day Year	3. Time of Death 3:00p M
	/Medic Examir		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of	of Death	4c. County of Death	
4	en.		104 S. Queen St. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year It Under		Kent a Right	place (Chate or Former
	Funeral Director		217-42-7254 1□M 2晃F 60 Yrs. Months Days Hours	Min. (Month, July	Day, Year) Cou	place (State or Foreign intry) 'Yland
	pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location			
	the Maryland 28a-f show notified at	5				10d. Inside City Limits 11 Yes 2 □ No
	the 288	rect	MD Kent Chestertown 10e. Street and Number 10f. Zip Code		10g. Citizen of What Cou	**
	with S	i D	104 S. Queen St. 21620		U.S.A.	
	dea E	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican	gin? (Specify Yes or	No- 14. Race - Ameri	
36	a o	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1 □ Yes 2 □ No Specify:	,, , , , , , , , , , , , , , , , , , , ,		hite
5-0036			15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/Ir	
215	⊆	Completed	(Specify only highest grade completed) Give kind of work done during most life. DO NOT use retired) (Give kind of work done during most life. DO NOT use retired)	t of working	100.11110 01 2031103311	idustry
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nd	be filed ntal Hygi od other event, I	Be			dle, Maiden Surname)	
Maryland	should be nd Menta marked imatic ev	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number	elle Sta		- 0-11
Ma	s 1 and 2 should be filed f Health and Mental Hyg item 27 ia marked othe other traumatic event,		Harold Brown Jr. (son) 12296 Still Pon			,
ē,		1	20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City or T	
imo	nit. Page artment c ortant: If injury or		1	1/14/06	6 Chestert	own, MD.
Baltimore	permit. Pac Departmen Important: any injury o		21. Significe of Firmeral Service Coanses 22. Name and Address of Facility Galena Funeral M00510 118 West Cros	Home of St. Ga	of Stephen	L.Schaech 21635
	Physician /Medical Examiner		23a Namt Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lue to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to or as a consequence of):	cardiac or respirator	y arrest,	Approximate Interval Between Onset and Death Murity
,0928	icate be executed physician and s the burial-transit	dical Examiner	ri any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last C. A Court, Inwin out of the consequence of the consequenc	loop &	sladda (cach light of time
.O. Box 6	w requires that the death certifica been signed by the attending ph should be detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 1 ☐ Yes 2 12 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ 9 ☐ Unknown		23d. Date of delive	ery Day Year
ords, P	requires that the een signed by th hould be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		id tobacco use contribute to t ☐ Yes 2 BNo 3 ☐ Prot	
of Vital Records,	The la ate has page 2	Completed		24a. W au pe 1 □ Yes	arformed? prior to co	ppsy findings available mpletion of cause of
Ĭ.	Physician: this certificinal director,	Be	examiner:	of Death Check onl		
of	F = E	. To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		esidence 6 Other (Special	(y)
ion	Attending in death. ector: After by the fune	ation	1 Denatural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ N	No		
Division	in Sire	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		n (Street and Number or Rura Town, State)	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death and manner stated.	d place, and due to the time	he cause(s) and manner as s ee, date and place, and due to	tated. o the cause(s)
)	To the To the complet	Σ	29b. Signalure and title of certifier 29c. License number DZ/3/3		29d. Date signed (Month,	Day, Year)
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
	Sto	10	Kin Kue Wun, M.D. 415 Washington Ave. Cl 31 Date filed (Month, Day, Year) 32. Registrar's Signature	hesterto	wn, MD. 216	20
	Sta Registr		JAN 1 8 2006 from the Sports			
DH	MH 17 Rev 1/20	001	OLULT O 7000 VICTORY SA			

ORIGINAL

			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of F rtificate of			giene) ()6	01163
	Dhusisi	~ M	1. Decedent's Name (First, Middle, Last,					2. Date of Dea Month	Day	Year	3. Time of Death
	Physici /Medic			3 ledsoe				January		2006	8:33 P M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death		4c. Coun	ty of Death	
			Homewood Retireme 5. Social Security Number 6. Sec	7 6	(In yrs. last birthday)	If Under 1 Year	liamspor	8. Date of Birt	h		ington
	Funeral Director		214-36-0734	м 211 / Age	66 Yrs.	Months Days		8. Date of Birt (Month, Day May 12			place (State or Foreign ntry) Yland
			Usual Residence of Decedent					111019 12	, 1222		
	how	_	10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits 1 ☐ Yes ※XNo
	86-1 e	Directo	Maryland Washing	ton		Williams	port				
	vith th	Dire	10e. Street and Number		4.00	10f. Zip Code			10g. Citizen o		
	s 23c	Funeral	16505 Virginia Av	12. Was Decedent E		217		activ Yes or No	14. R	USA ace - Amen	·
	Item de	'n.	11. Marital Status 1 X Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 💢 N	0		Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	81	ack, White,	
336	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Spec	ify: W	/hite
21215-0036	72 hours after death with the Maryland naturel', or Items 23a or 26e-f ehow dical Examinar must be notitied at	Completed by	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual Occup	pation during most of work	kuna	16b. Kind of	Business/In	ndustry
218	within 7 ene. then "r he Med	uple	Elementary/Secondary (0-12)	College (1-4or 5-	life.	DO NOT use retire	od)	way .			
	filed withi Hygiene. Ither ther		12			Libraria	18. Mother's Nam	a /Final Middle			Society
pu	be fill of oth	Be	17. Father's Name (First, Middle, Last)					,		ŕ	
7	should be nd Mental marked o	2	Robert Lindsay E		10h Maili	na Address (Street	Mary L and Number or Ru	arthea	Ingram		n Codel
Maryland	C 40 m 2										ort,MD 21795
	s 1 and of Health Item 27 other tr		Mary Darthea Bleds 20a. Method of Disposition	oe-Mother	20b. Place of Disponentery, cre-	sition (Name of	ia nve. n	Date 1190	20c. Location		
no io			1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State			ry Jan.1	1 2006	Hagors	town	Maryland
Baltimore,	permit. Page Department of Important: If eny Injury or ance.		21. Signature of Funeral Service Licens	99			neradiiyHom		nagers	o i Owii,	mai y land
B	Depar Impor						ococheagu	•	lliamsp	ort,M	D 21795
đ.	25		23a. Part : Enter the disease, or complishock, or heart failure. List only o	ications that caused	the death. Do not en	ter the mode of dy	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	D	•						Onset and Death Luce K
	/Medical		resulting in death)		consequence of):			-			IWEER
	Examiner		Sequentially list conditions	Chron	10 Obs+	-ructive	e hung	Disco	rse		years
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):		8				/
	ecute and -trans	Examiner	that initiated events resulting in death) Last	Due to for as a	consequence of):						
8760,	cate be executed obysician and the burial-transit			Due to (or as a	consequence on.						
87	The law requires thet the death certificate be executed ate hes been signed by the attending physician and bage 2 should be detached for use es the burial-transit	Physiclan/Medical	•	d							
9 x	eath certific attending p	/Me	IF FEMALE:	3c. If yes, outcome of	of pregnancy				23d. D	ate of deliv	erv
Box	atter atter	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t		Ectopic pregnanc Other (specify)	у			onth	Day Year
P.O.	by the a	isk	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown							
	res thet igned b be deta	by Pl	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use co	ntribute to t	the cause of death?
rds	w require: been sign should be	pe pe	Rheumatoid	Arthri	1-is			1 🖫	es 2□No	3 🗌 Prot	bably 4 □Unknown
000	sw request speed	olet	Clastridium	DIFFICIL	e Infe	ction		24a. Was		. Were auto	opsy findings available ompletion of cause of
of Vital Records,	The lav	Completed	Seizure Diso	rder				perfo	med?	death?	
ita	ilcian: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?	1001			26. Place of Dea	th (Check only o	ne)		
<u>\$</u>	S S	10	1 Yes 2 No	lospital: 1 Inpatier		IL 3L DOA		ome 5 Resid			fy)
D C			27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injun (Month, Day	Year) 28b. Time o	Wo		28d. Describe h	low injury occi	urred	
sio	tend leath tor: the	catl	2 Accident investigation 3 Suicide 6 Could not be		A15		Yes 2 □No	201 Leasting /6	Stands and Miss	ahas as Rus	al Courte Minister
Division	or Attending after death. Director: Aftar In by the fune	Certification;	4 Homicide determined	building, etc	ry - At home, farm, st . (Specify)	reet, factory, office		City or Tow		nber or Hura	al Route Number,
	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by		29a. Certifier 1 Certifying Phy	sician: To the hest o	f my knowledge, deat	h occurred at the fi	me, date and place	and due to the	cause(s) and n	nanner as s	stated.
	To the Hospitel within 24 hours of To the Funerel completely filled	edical	(Check only 2 Medical Exami	ner: On the basis of and manner stat	examination and/or in	vestigation, in my	opinion, death occu	rred at the time,	date and place	e, and due to	o the cause(s)
	omple	Me	29b. Signature and title of certifier			29c. Licen:	se number		29d. Date sign	ned (Month,	Day, Year)
	~ > = 0		Dametea K	uttrer - S	sand, w	D4-	7451	J	anuar	48.	2006
			30. Name and address of person who co	ompleted cause of de	ath (Item 23a) (Type,	Print)	Church	Road	Hazer	Stown	Macyland
151	H-/		30. Name and address of person who c Cynthia Kuthner - Si	ands MD	14214 PO	radise	-1,100,011	21742			, The state of the
. .3	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature						
100	Regist	rar	JAN II 2	JUG Jules	~ B. A.	will					

Mangaret 7, Bledsoc

			1 = For State Registrar	State of Maryland		artment of			giene 0 0	6 01164
# 150 2 150 2 150 3 150	Physici		1. Decedent's Name (First, Middle, Last James Melvin					2. Date of Dea Month January	Day Y	3. Time of Death 6:55 p.M.
	/Medic Examin Funeral Director	i	4a. Facility Name (If not institution, give St. Mary s N 5. Social Security Number 6. Se	street and number) ursing Center	- V			wn s. 8. Date of Birt	4c. County of St. h y, Year)	
7	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Be-f sh	ector		lary's (Great 1					1 ☐ Yes 2 No
	with t	i Dir	10e. Street and Number 45720 Sayre Drive			10f. Zip Cod 2063			10g. Citizen of Wh United	-
	ms 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. V		of Hispanic Origin? (Suban, Mexican, Pue	Specify Yes or No- orto Rican, etc.)		American Indian, White, etc.
9036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show fra Modical Exartii or must be ustiffed at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ■ No If Yes, Give Year or Dates:		1 ☐ Yes 2 █ 1			Specify:	Black
21215-0036	hin 72 hv r. In "natu Medicul	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Oc kind of work do DO NOT use re	ne during most of w	orking	16b. Kind of Busi	ness/Industry
21	ygiene ygiene her tha	Com	10	Oblings (1. 40. 61)	J	anitor	10.11.11.11		Janito	rial
Maryland	utd be fil Vental H irked ott itic even	To Be	17. Father's Name (First, Middle, Last) Albert Butler, Sr					ame (First, Middle, Ann Mill	,	
Mary	nd 2 sho lith and I 27 ie ma r trauma		19a. Informant's Name/Relationship (7) Kathy Butler/Dau				Drive, G		-	
	iges 1 ar nt of Hea : If item or other		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ F	Removal from State	metery, cren	sition (Name of natory or other	place)	Date	20c. Location - Ci	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural; or items 23a or 28e-f show any righty or other traumatic event, the Medical Examini or must be utilified at ODGs.		4 □Donation 5 □Other (Specify, 21. Signature of Fundau S Edward N. Brinsfie	in)	22		dress of Facility			nes, MD 1 Home, P.A. MD 20650
8760,	Physician /Medical Examiner in pright and pr	cal Examiner	23a. Part1. Enter the disease, or comp shock, or heart lailure. List only o Immediate Cause (Final disease or condition resulting in death) Sacuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	vence of:	roma AB	1	ec or respiratory ar	rest,	Approximate Interval Between Onset and Death MUNUTAL
P.O. Box 687	death certifica e attending ph of for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	o. 23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time ol de 9 Unknown	death 3	Ectopic pregna Other (specify			23d. Date of Month	
	quires that n signed b uld be deta	þ	Part II. Other significant conditions co	ntributing to death but not resu	Iting in the ur	nderlying cause	given in Part I.			ute to the cause of death?
al Records,	ysician: The law requires that the is certificate has been signed by th director, page 2 should be detach	Completed						24a. Was autop perfor 1 Yes	sy price dea	ore autopsy findings available or to completion of cause of ath? Yes 2 M No
Vital	Physician: this certific ral director.	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 Ø No	Hospital: 1 ☐ Inpatient 2 ☐ E	D/O::t==t:==	4 0U DO4	Othor	eath (Check only o		(0.11)
Division of	Attending Phy ir death. ector: After this by the funeral d	 -	27. Manner ol Death 1. Natural 5 Pending 2 Accident Investigation		28b. Time of Injury	28c. I	njury at Work? 1 Yes 2 No	Home 5 Resid	now injury occurred	
Divisi		Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify,	me, farm, str	eet, lactory, offi	ice	28l. Location (S City or Tow		or Rural Route Number,
	Hospitel or 24 hours efte Funerel Dir etely filled in	edical C		sician: To the best of my know iner: On the basis of examinati and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier	A larle	AAI	29c. Lic	ense number	10	29d. Date signed (Month, Day, Year)
7	\sim		30. Name and address of erson who c	omplet suse of death (Item	23a) (Type,	Print)	UUT	1/	1-10-	06
	numpte si		James P. Jarbo	oe, 24035 Thre		ch Road	, Hollywo	od, MD 20)636	
i i	Sta Registi		JAN 1 1	2006	JF.	Sie Le	9			

			1 - State Registrar	State of Marylan		artment of H			giene Reg. No:	41115	01165
	Physici		1. Decedent's Name (First, Middle, Last) Shelia Mae	Brooks				2. Date of De Month Januar	ath Day		3. Time of Death 5:40 A M
	/Medic Examin		4a. Facility Name (If not institution, give s 5133 Rhodesda1e-E1			4b. City, Town, or Rhodes			4c.	County of Deat	
	Funeral Director		Social Security Number		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th ly, Year)	9. Birtl	hplace (State or Foreign untry) W York
	show ad at	٥٢	10a. State 10b. County MD Dorche		y, Town or Lo	cation esdale					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28a-f	Director	10e. Street and Number			10f. Zip Code			10g. Citi:	izen of What Co	**
036	d within 72 hours after death with the Maryland jene. rt then "naturel", or iteme 23a or 28a-f show the Medical Examires must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2-Eldorado I 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	.S. 13. V	216 Was Decedent of H if Yes, specify Cuba		Specify Yes or No to Rican, etc.))-	ted St 14. Race - Ame Black, White Specify:	rican Indian,
21215-0036	within 72 ane. then "na	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 1	cation o <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired Giver	ation furing most of wo)	orking		nd of Business/	,
Maryland 2	be file tal Hyg d othe event,	To Be Co	17. Father's Name (First, Middle, Last) Sonny Gildersl	eeve				me <i>(First, Middl</i> e, e Morri		Sumame)	
Mary	nd 2 should lth and Men 27 le marke traumatic		19a. Informant's Name/Relationship (Type Benjamin L. Brooks			Rhodeed					_{пр Соде)} е, MD 21659
Baltimore,	Pages 1 and 2 nent of Health int: if item 27 inty or other tra		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Dispo cemetery, cren	sition (Name of natory or other place	e)	Date	20c. Lo	cation - City or	
Balti	permit. Pages Department of the Importent: if ite eny injury or of once.		21. Signature of Funeral Service License	sku	22	Name and Address	ain St	., Fede	rals	neral sburg,	Home, P.A. MD 21632
8760,	Physician physician and physician and physician and physician and the physician in the private and the physician phy	dical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence).	uenca of):	er the mode of dyin		c or respiratory a	rest,		Approximate Interval Between Onset and Death 2 Monday
.O. Box 6	Physicien: The law requires that the death certif this certificate hes been signed by the attending i ral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25□No 9 □ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of digital Unknown	death 3	Ectopic pregnancy Other (specify)			2	23d. Date of deli Month	very Day Year
rds, P.	w requires that been signed by should be deta	þ	Part II. Other significant conditions con	tnbuting to death but not resu	ulting in the ur	nderlying cause give	en in Part I.	23e. Did to			the cause of death?
Division of Vital Records,	i: The law requicate hes been	Completed						24a. Was autor perio 1 - Yes		death?	topsy findings available completion of cause of 2 No
f Vit	nysicier nis certif director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No He	ospital: 1 Inpatient 2	ER/Outpatien	t 3□ DOA Othe		ath <i>(Check</i> on <i>ly c</i> Home 5∭ Resid		3 □Other (Spec	ify)
ion o	anding Pt ath. or: After th		27. Manner of Death 1 Autural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	rat c? Yes 2 □ No	28d. Describe h	now injury	y occurred	
Divis	To the Hospital or Attending Physicien: The within 24 hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	y) 			City or Tox	vn, State))	ral Route Number,
	To the Hospital within 24 hours To the Funeral completely filled	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my kno ner: On the basis of examina and manner stated.	wiedge, death ition and/or inv	occurred at the time vestigation, in my op-	e, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	0200		29c. License			29d. Date	e signed (Month	, Day, Year)
		1	30. Name and address of pers in who con		1110 n 23a) (Type, I	Print)	4723	2	- {	110101	0
		•	Mary S. DeShiel 31. Date filed (Month, Day, Year)			lewild	Ave.,	Easton,	MD	21601	
3,	Sta Registr		JAN 1 % 200	32. Registrar's Signa	Is A	ranks!					

			State of Manuard / Dans			•	
			State of Maryland / Department	aitment of Health and M rtificate of Death		711116	01166
			Registrar 1. Decedent's Name (First, Middle, Last)	Timeate of Beatif	2. Date of Death	. No. 9 0 0	3. Time of Death
	Physicia	an	Mattie Ellen Bordley		Month Janaury	6 2006	6:05 ^M A
	/Medic Examin	B	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	January	4c. County of Death	0.05 11
	Examin	ei	Corsica Hills Nursing Home	Centreville		Queen Ann	ne
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Y Jan 2 19		place (State or Foreign ntry)
	Director		220~07~3439 1□ M 2☒F 96 Yrs.		Jan 2 19	10 Mary	land
	pue *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Le	ocation			10d. Inside City Limits
	daryli f sho	ō	Maryland Queen Anne Centre	vri 11 o			1X Yes 2 No
	28a	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	ntry?
	72 hours after death with the Maryland natural', or items 23s or 28s-f show diest Examinat must be rediffed at	D	205 Armstrong Ave.	21617		USA	
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
92	or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	1 ☐ Yes 2X No Specify:		Specify:	1
21215-0036	ural',	d by	3 X Widowed 4 □ Divorced Year or Dates:	dent's Usual Occupation	16	B1a	
15	"nat	Completed	(Specify only highest grade completed) (Give	kind of work done during most of worki DO NOT use retired)	ng	b. King of bbolliogs/il	dustry
12	within iene. than "	L O	Elementary/Secondary (0-12) College (1-4or 5+) poult	ry processor		poultry in	ndustry
	i Hygie other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	iden Sumame)	
lar	Mentai Mentai rked c	To B	Samuel Pearce	Martha (ı	ınknown)	Pearce	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Modical Examinar must be colified at	ľ	Total Wilder and Total Control of the Control of th	ng Address (Street and Number or Rura			
	1 and 2 Health tem 27 l			Sunset Blvd, Apt			
ore			1 ABurial 2 Cremation 3 Hemoval from State	matory or other place)		c. Location - City or To	
Baltimore,	artmen ortant: injury g.			sion Cemetery 01/12	1/06 B	ridgetown,	Maryland
Bal	permit. Page Department o important: if any injury or once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Fleegle and Helfent O Box 160 Greensbo	ein Fune oro, MD 2	ral Home, 1639	PA
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition Was curlan dismes	rtea			Onset and Death
	/Medical		resulting in death)				
п	Examiner		Sequentially list conditions, b. Lanebrows Culler	accident			epers
	pe is	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events b. Due to (or as a consequence of): Appellansis on			-	1 . 22 1 1
_	siclan and burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):				Jung
760	te be executed ysiclan and e burial-transit	cal E	At Kenoschenosis				years
687	ificate g phys as the		<u> </u>				
Вох	The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 [□Ectopic pregnancy		23d. Date of deliv	,
-	ne deat the atte	sicia	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5[Other (specify)		Month	Day Year
P.O.	that the do ed by the detached	Phy	9 Unknown	inderkeing gaves group in Bort I	23e Did tohai	cco use contribute to t	the cause of death?
	uires tha signed Id be det	by	Part II. Dther significant conditions contributing to death but not resulting in the a	nidentying cause given in Facci.		2 □ No 3 □ Pro	. /
Records,	w requ	Completed			24a. Was an	24h Were aut	opsy findings available
3ec	has has ge 2 s	mpl	Organic brain syndrome		autopsy performe	prior to co death?	ompletion of cause of
a	n: The ficate or, page	e Co	25. Was case referred to medical	26 Place of Death	1 ☐ Yes 2 (Check only one)	No 1 ☐ Yes	2□ No
Vital	Phyaician: The ia this certificate have ral director, page 2	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Othor		ce 6 ☐Other (Speci	fy)
of	g Phy er thi		27. Manner of Death 28a. Date of Injury 28b. Time of Manner of Death Pay Years	of 28c. Injury at Work?	28d. Describe how	injury occurred	
jo	ttendin death. ctor: Aft / the fur	atio	2 Accident investigation	M 1 Yes 2 No			
Division	i or Atte after de Directo	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town, .	et and Number or Run State)	al Route Number,
	pital o		29a. Certifier Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place	and due to the cau	se(s) and manner as s	stated
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	exestigation, in my opinion, death occurr	ed at the time, date	e and place, and due t	to the cause(s)
	withir To th	ž	29b. Signature and title of certifier	29c. License number	290	I. Date signed (Month,	
			IMM row from	DZ-5933		1.10.06	
			30. Name and address of person who completed cause of death (Item 23a) (Type Michael D. Croples, MD, 610 Dulu	Print) Imans Lane, Easto	m Mis ?	21601	
	Sta	ate	24 Date filed (Month Day Vond) 22 Booktrade Signature		11) 100		
	Regist		JAN 1 0 2006	doct			

			1 - For State Registrar	State of	Maryland / Depa	artment of F			jiene	06	01167
	División		1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea	th		3. Time of Death
	Physic /Medi		PETER	BEATON				JANUAR	Y 1 2	Year 006	1:25 P ^M
	Exami		4a. Facility Name (If not institution, g.			4b. City, Town, o	r Location of Dea	ith	4c. County	of Death	
			CHARLOTTE HALL				TTE HALI			MAR	Y'S
	Funeral Director		108-14-4431	Sex 7 1 ☐ M 2 X XF	. Age (In yrs. last birthday) 87 Yrs.	Months Days	If Under 24 Hr Hours Mir		Year) 8,1918	9. Birthp Coul SC	place (State or Foreign ntry) TLAND
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	he Marylan :8e-f show otified at	Director		GEORGE'S	BOWIE						1⊠Yes 2□No
	with t	ä	10e. Street and Number	T 7 4 37		10f. Zip Code		1	0g. Citizen of \	What Cour	ntry?
	leath ns 23	Funeral	15105 PLUM TREE	12. Was Deced	ent Ever in II S 13	20721	ianania Origina /	Casaita Van an Na	U. S		can Indian.
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "neturel", or items 23e or 28e-f show event, I're Madical Examination using a point of the Madical Examination of the Madical Ex	by Fun	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force	∐ No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specity:	to Rican, etc.)		k, White,	etc.
9	2 hou	ted	15. Decedent's E	ducation	16a, Dece	dent's Usual Occupa	ation		16b. Kind of Bu	WH]	
21215-0036	within 7 ene. then "n	Completed	(Specify only highest gi	College (1-4	or 5+)	kind of work done o DO NOT use retired		orking		311003111	oudily
d 2	filed with Hygiene. Ither ther		17. Father's Name (First, Middle, Las	5-	F AEROI	NAUTICAL		me (First, Middle, M	AERONA		5
/lan		To Be	DAVID BEATON	7				HARDIE	naiden Sumam	ie)	
Maryland	and and is m		19a. Informant's Name/Relationship HELEN BEATON /		19b. Mailir	ng Address (Street a	and Number or R	ural Route Number,	City or Town,	State, Zip	Code)
	s 1 and if Health item 27 other tre		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	T		20c. Location -		
altimore,			1 √2 Burial 2 □ Cremation 3 [`4 □ Donation 5 □ Other (Speci		GREENWOOI	natory or other place CEMETER		.6,2006		,	
Balti	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Lice	nsee ST	22	. Name and Addres	s of Facility BR	INSFIELD- RD. CHARI	-ECHOLS	FUNL	. HME.,P.A
			23a. Part1. Enter the disease, or con	plications that cau	sed the death. Do not ent					ال و بالله	Approximate
i	Pnysician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on eac	nd Stage					008	Interval Between
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):	1	1	mer's	<u> </u>	د د ع	e year
		er	Sequentially list conditions, if any, leading to immediate	b. — Due to for	යා ය ර්ග්ර්මේඛ්‍රයේ රට්.	hype	v ten	11 W			
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	223.0 (0.	a a sonsequence on.	\mathcal{O}'					
oʻ	an an irial-tr		resulting in death) Last	Due to (or	as a consequence of):						
68760,	ficate be executed physician and s the burial-transit	edicai		d							
~			IF FEMALE:	00-14		<u> </u>					
Вох	death certiff e attending ed for use as	cian	23b. Was decedent pregnant in the past 12 months?		1 2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of delive	ry Day Year
P. O.	0 0	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknow		Other (specify)					
S, F	es pe	by	Part II. Other significant conditions	contributing to deat	h but not resulting in the un	nderlying cause give	n in Part I.	23e. Did toba	acco use contri	bute to the	e cause of death?
Records,	w requir been si should	Completed	Denign	TIOS TE	anc ny	pernor	my	1 🗆 Yes	3 2 □ No	3 🗌 Proba	ably 4 Onknown
3ec	e law has b	mple				<u>'</u>		24a. Was an autopsy	pi	rior to com	sy findings available
			OS Was seen after the services					perform 1 ☐ Yes 2		eath?	2 4 No
>	Attending Physicien: r death. ector: After this certifics by the funeral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpa	atient 2 ER/Outpatient	Othe		ath (Check only one			
סר	ding Phys n. Atter this funeral di	L id	27. Manner of Death	28a. Date of I	njury 28b. Time of	28c. Injury	at	lome 5 Resider 28d. Describe how)
Sior	endin eath. or: Af	atio	1 Natural 5 Pending 2 Accident investigatio	n	Day Year) Injury	M 1 ☐ Y	es 2 □ No				
Division of	or Atten after deatl Director; in by the	Certification;	3 Suicide 6 Could not be determined	286. Place of	Injury - At home, farm, stre etc. (Specify)	et, factory, office		28f. Location (Stre City or Town,	et and Numbe State)	r or Rural	Route Number,
_	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Pr	iysician: To the he	st of my knowledge, death	occurred at the time	a date and olon-	and due to the	100(0) ====		
	he Ho n 24 h he Fu	edical	(Check only 2 Medical Examone)	niner: On the basis and manner	s of examination and/or inv	estigation, in my opi	inion, death occu	rred at the time, dat	e and place, ar	ner as sta nd due to	the cause(s)
	To t		29b. Signature and file of certifier	N	211	29c. License	number	29	d. Pate signed	(Month, D	lay, Year)
			Janel	00	m Mo	0450	042	/	103	12	006
1	8 1A31		30. Name and address of person who	completed dause of	f death (Item 23a) (Type, F	Print))	Fredv	/	1.7	2.120
ú	Sta	te	31. Date filed (Month, Day, Year)	32. Re	SWE #	- 405	rince	reav	1 Clc	MI	106 18
10	Registra	-	JAN 0 4	2006	Mese B. A	pour					

ind 21215-0036
Maryla
Baltimore,
68760,

VIVIAN C. BELCHER

			For State Registrar	State of M	larylar			nt of H te of L		nd Me		giene Reg. Nő.	00	6	01168
			Decedent's Name (First, Middle, Last	")							2. Date of Dea	ath			3. Time of Death
П	Physicia		VIVIAN CAROL E	BELCHER,	PHI)					Month Januai	Day 1. y 4		Year Об	1:36P M
	/Medic Examin		4a. Facility Name (If not institution, give		-		4b. City	, Town, or	Location of	Death			County		
Н	CAGIIIII		Civista Medical	Center			La	a Pla	ta				Cha	rles	
	Funeral		5. Social Security Number 6. Se		ge (In yrs.	last birthday)	If Unde	r 1 Year Days	If Under 2	4 Hrs.	8. Date of Birt (Month, Day	h (Vaar)			lace (State or Foreign
Ш	Director		235-54-9421	□M 2XQF	73	Yrs.	Months	Days	Hours		III.Y 5		32 l		VTRGINI
	P .		Usual Residence of Decedent		140 0									1.	
	anylar show	_	10a. State 10b. County		10c. CI	ty, Town or Lo	cation							1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	89-1 s	ct	MARYLAND CHARLE	!S		WALDO									
	or 2	Director	10e. Street and Number				10f. Zi	p Code				10g. Citi:	zen of W	hat Coun	itry?
	ath w		820 COPLEY AVE.					206					.S.		
	tems	Funerai	11. Marital Status	Was Decedent Armed Forces	?	J.S. 13. \	Nas Dece f Yes, sp	edent of His ecify Cubar	spanic Origi n, Mexican,	in? (Spec Puerto R	city Yes or No- lican, etc.)			. Amend	an Indian, etc.
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes XX If Yes, Give Year or Dates:			1 🗆 Yes	2 ⊠ No	Specify:				Specify:	T _A T LI	ITE
5-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28e-f show the Medical Exist in err. wat be notified at	De la	15. Decedent's Edu			16a Dece	lent's He	ial Occupa	tion			16b Kir	nd of Bus	siness/Inc	
<u>.</u>	n 72 "na nalic	Completed	(Specify only highest grad	de completed)		(Give	kind of w	ork done d use retired)	ition <i>furing most (</i>	of working	g				OUNTY
2121	with ene. ther	mo	Elementary/Secondary (0-12)	College (1-4or	5+)	DRT	NCI	DΔT							EDUCATIO
	filled Hyg other ent,	BeC	17. Father's Name (First, Middle, Last)						18. Mother	's Name	(First, Middle,	Maiden	Sumame	9)	
aryland	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "naturel", or Items 23a or 28e-f show eumatic event, the Madical Exacting Etc. and the notified at	To B	CECIL RICE BRAY	7					THEL	MA V	IRGIN	IA	MC (CALL	ISTER
ary	s 1 and 2 should f Health and Men item 27 Is marke other treumatic	_	19a. Informant's Name/Relationship (T)	ype, Print)		19b. Mailir	ng Addres	s (Street a	nd Number	or Rural	Route Numbe	r, City or	Town, S	State, Zip	Code)
Σ	ロモアラ		ROBERT E. BELCH	HER-SPOU	JSE	820	COP	LEY	AVE.	, WA	LDORF	, M	D 20	0602	
ē,	s 1 a f Hez item othe		20a. Method of Disposition			Place of Dispo	sition (Na	me of	9)	Da	ite	20c. Lo	cation - (City or To	wn, State
Ë	Pages nent of H ent: If ite		1 Durial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		ARYI	-	-		CEM.	. 01	-12-0	6 C	HELT	renh	AM, MD
altimore,	그는은 중		21. Signature of Funeral Service Licens		1004	79 22	. Name a	nd Addres	s of Facility		<u></u>				
ñ	Depar Depar Impo any ir		171 Cula	(X		F	MYAS	OND	FUNE	RAL	SERVI	CE,	P • A	Α.	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause	d the dear	th. Do not ent	er the mo	de of dying	, MAI , such as c	AYLA ardiac or	respiratory ar	646 rest,			Approximate Interval Between
п	Dhysisian		Immediate Cause (Final	ne cause opeach	ine.	1-	30	000	' a	3.0.					Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	s a consec	nuence of):		rusy	U	OVU					
r	Examiner					,									
١.		e	Sequentially list conditions, if any, leading to immediate	Due to (or as	s a consec	(uence of):									
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C											
o î	execan an an rial-tr	EX	resulting in death) Last	Due to (or as	s a consec	quence of):									
8760	cate be executed physician and the burial-transit	dicai	(d											
9		(D)	IS ESCHALS												
ŏ	eath certifi attending p	an/N	23b. was decedent pregnant	23c. If yes, outcome 1 Live birth			Ectopic o	regnancy				2		of delive	*
	dea ne att	Sici	in the past 12 months? 1 Yes 2 ZNo	4☐ Pregnant a 9☐ Unknown			Other (s	pecify)					Mon	un	Day Year
P.O. Box	at the by the	Physician/M	9 Unknown												
	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant conditions co	ntributing to death t	but not res	sulting in the u	nderlying	cause give	n in Part I.						e cause of death?
Records,	w require been si should b	Completed									1 🗆 Y	es 20	ELNO .	3 100	ably 4 □Unknown
e C	law ras be	pie									24a. Was autop	sy	24b. W	ere autor	osy findings available inpletion of cause of
œ e	vysicien: The laviscentificate has director, page 2	mo:									perfo	med? 2 No		eath? □ Yes	2 No
ita	len: rtifica ctor,	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o	ne)			
>	Physicien: r this certifica ral director, p	To	1 ☐ Yes 2 PNo	Hospital: 1 Inpati	ient 2	ER/Outpatien			4 🗆 Nurs	sing Hom	e 5 🗆 Resid	ence 6	Othe	r (Specify	n .
Division of Vital	or Attending Phater death. Director: After thin by the funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury a <i>y Yəar)</i>	28b. Time of Injury		28c. Injury Work			3d. Describe h	ow injury	occurre	d	
0	Attending or death. ector: After by the fune	ati	2 Accident investigation				М		′es 2 □ N						
ž	I or Attendation after death	Certification;	3 Suicide 6 Could not be determined	28e. Place of In building, e	njury - At h etc. <i>(Speci</i> i	ome, farm, str fy)	eet, facto	ry, office		28	3f. Location (S City or Tow			r or Rura	l Route Number,
0	itel or saft														
	Hosp 4 hou Fune ely fil	edicai	(Check only 2 Medical Exam		of examina										
	To the Hospitel of within 24 hours af To the Funerel Completely filled in	Med	one)	and manner s	tated.		20	c. License	number			29d. Date	sinned	(Month I	Day, Year)
	T Vit		29b. Signature and title of certifier	1/10-			1				1 '			-0	
			Hames	///	1			D-5	52919			/	- 0	-0	Ø
	10		30. Name and address of person who c						1	100				_	
			Jame's I. Harring 31. Date filed (Month, Day, Year)	, MD 1UZ	Cente	ennial	Stre	et, S	uite	102.	La Pl	ata,	Mar	ylan	d_20646
	Sta Registr		JAN 2 0 2006	Alberta		ature									

Registrar

Elmer Brickerd
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, <

		State of Maryland / Dep.	artment of Health	n and Mental Hygie	2006 01169
为 公主		1. State Registrar Amend Item #1&19b Per INF G852 1. Decedent's Name (First, Middle, Last)		2 Date of Death	3. Time of Death
Physicia /Medic		Elmer Webster 1	Brickerd, JR.	January	Day Year 5, 2006 2:59P M
Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location	on of Death	4c. County of Death
	Æ .	Civista Medical Center	La Plata	der 24 Hrs. 8. Date of Birth	Charles (State of Series
Funeral Director		5. Social Security Number 6. Sex 1 M M 2 F 7. Age (In yrs. last birthday) 6. Yrs.	Months Days Hour		9. Birthplace (State or Foreign Country) MARYLAND
pu k		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Letter	ocation		10d. Inside City Limits
deeth with the Maryland ms 23a or 28a-f show	o	MARYLAND CHARLES WALDORI			1 ☐ Yes 2X XNo
r 28a-	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
ath wit	raiD	3100 HEATHCOTE ROAD	20602		U.S.A.
er dee	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic If Yes, specify Cuban, Mexi	Origin? (Specify Yes or No- ican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
irs aft	by	Mixing a constraint of the co	1 ☐ Yes 2 ☒ No Spec	eity:	Specify: WHITE
72 hou	eted	15. Decedent's Education 16a. Dece	dent's Usual Occupation a kind of work done during π	nost of working	. Kind of Business/Industry
Men.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	(-	GARRICK & GABE
Hygie ther t ant, the		12 TRU(CK DRIVER	other's Name (First, Middle, Maid	
lid be lental rked o	To Be	ELMER W. BRICKERD, SR.	E	ETHEL CYLESTA	TAYLOR
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. By injury or other traumatic event, its Modical Examiner must be notified at once.		1121	•	mber or Rural Route Number, Cit	00500
l and fealth m 27 her tr			O BADEN PL		. Location - City or Town, State
ages 1 nt of H : If Ite		1 Rurial 2/TYCremation 3 Removal from State	matory`or other place)		LEXANDRIA, VA
nit. Pa artmer ortant injury			AN CREMATOR 2. Name and Address of Fa		LEANDRIA, VA
Depar Impo		21 000	RAYMOND FUN	NERAL SERVICE	
		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause op each line.	ter the mode of dying, such	as cardiac or respiratory arrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition			Onset and Death
/Medical Examiner		resulting in death) Due to (or as a consequence of):	SERVICE ON		
	er	SMALL BOWEL OBS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	STRUCTION		
outed ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events C.			
te be executed ysicien and e burial-transit	al Exa	resulting in death) Last Due to (or as a consequence of):			
physic physic the b		d			
deeth certificate e attending phys d for use as the	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	7- 242		23d. Date of delivery
deeth ne atte ed for	Physician/Medio	in the past 12 months? 1 Yes 2 No 1 Yes 2 No			Month Day Year
oet the d by the	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the u	underhing course given in Pa	23a Did tohace	to use contribute to the cause of death?
The law requires thet the deeth certificate title has been signed by the attending phy: page 2 should be detached for use as the	d by	Partin. Other significant continuous contributing to dealin out not resulting in the c	indenying cause given in ra	1 ☐ Yes	2 No 3 Probably 4 Unknown
been should	ompleted			24a. Was an	24b. Were autopsy findings available
The lav	mo:			autopsy performed	
ician: Th	BeC	25. Was case referred to medical examiner?		ace of Death (Check only one)	
Physi this c al dire	٦.	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Magner of Death 28a. Date of Injury 28b. Time of		Nursing Home 5 Residence 28d. Describe how in	
ding th: : After fune	tion	1	Work? M 1 ☐ Yes 2		nary occasion
r Atter er dea rector by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number,
oltal o					,
To the Hospital or Attending Physician: Thin 24 hours after death as the found to for the Funarel Director: After this certifica completely filled in by the funeral director, to	edicai	29a. Certifier (Check only one) Medical Examiner: Of the basis of examination and/or in and manner stated.	th occurred at the time, date nvestigation, in my opinion, o	a and place, and due to the cause death occurred at the time, date	a(s) and manner as stated. and place, and due to the cause(s)
To the To the Comple	Me	29b Signature and title of certifier	29c. License numb	er 29d.	Date signed (Month, Day, Year)
		by Tr/M	D-3342	26	1-5-06
941		30. Name and address of person who completed cause of death (Item 23a) (Type,	, Print)		
Sta	te	B. Larry Jenkins, MD 111 LaGrange Av 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ve. La Plata,	Maryland 20646)
Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 2 0 2006			

DHMH 17 Rev 1/2001

Registrar

			1 - For Stata Registrar	State of Maryland		nt of Health and e of Death		ene g. No. 006	01171
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last, Robert M. C 4a. Facility Name (If not institution, give)	onway, Sr.	4b. City,	Town, or Location of D	2. Date of Death Month January eath	Day Year	
	Funeral Director		Union Hospi 5. Social Security Number 6. Sec. 215–14–0007			kton r1Year If Under 24 I Days Hours N	Hrs. 8. Date of Birth (Month, Day, Tune 10	Ceci1 Year) 9. Birt Co , 1922	hplace (State or Foreign huntry) MD
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dies! Examirer must be notified at	Funeral Director	10a. State 10b. County MD Ceci1 10e. Street and Number	E	1kton		10	g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes Ye No untry?
5-0036	72 hours after death with the Maryla natural", or Items 23a or 28a-f shov dieal Examirer must be notified at	by	230 Me1bourne 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1√⊡Yes 2 □ No If Yes, Give Year or Dates: WWII	13. Was Decer If Yes, sper 1 ☐ Yes	**	erto Rican, etc.)	U.S.A. 14. Race - Ame Black, White Specify: Wh	ite
Maryland 21215-	filed within Hygiene. ther than "	Be Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 1 1 17. Father's Name (First, Middle, Last)	cation e completed) College (1-4or 5+)	16a. Decedent's Usua (Give kind of wo life. DO NOT u. Owner/0	perator	working 1	Shoe Inc	
	and 2 should be saith and Mental n 27 is marked o	7	Frances T. (19a. Informant's Name/Relationship (Ty Robert M. Conway	pe, Print)		Le (Street and Number or ttingham			Tip Code)
Baltimore,	permit. Pages 1. Department of He Important: If itan any injury or oth once.	10,000	20a. Method of Disposition 1	emoval from State E1kt	ton Ceme 22. Name an	ne of hther place)	uary 6,	Elkton,	Town, State
8760,	Provided and provi	dical Examiner	23a. Part 1. Enter the disease or complishock, or flear failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a a consequent	Do not enter the mod AN CLA noe of):		lac or respiratory alres		Interval Between Onset and Death WCAN YCALS
O. Box 687	death certific e attending p id for use as	Physician/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) 9 \(\subseteq \text{Unknown} \)	3c. If yes, outcome of pregnancy 1 □Live birth 2 □Fetal de 4 □ Pregnant at time of death 9 □ Unknown	ath 3 Ectopic pr			23d. Date of deliment	very Day Year
ords, P.	The law requires that the te has been signed by th age 2 should be detache	by	Part II. Other significant conditions cor	tributing to death but not resulting	ng in the underlying c	ause given in Part I.	1 ☐ Yes		obably 4 Unknown
of Vital Record	Physician: The lav this certificate has ral director, page 2	Be Completed	25. Was case referred to medical examiner?	VI DISCHE			24a. Was an autopsy performe 1 Yes 25	prior to c	topsy findings available ompletion of cause of
Division of \	ending sath. or: After he funer	ertification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide		М	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how 28f. Location (Stre-City or Town,	injury occurred et and Number or Rui	
	To the Hospital or Att. within 24 hours after de To tha Funaral Direct completely filled in by th	Medical Ce	29a. Certifier (Check only one) 1 ☐ Certifying Physical Exemination one) 1 ☐ Certifying Physical Exemination one)	icien: To the best of my knowlerer: On the basis of examination and manner stated.	and/or investigation,	at the time, date and pla in my opinion, death or License number	curred at the time, date	se(s) and manner as a and place, and due	to the cause(s)
8	+ VA	te	30. Name and address of person who co	mpleted callse of death (Item 23	Sa) (Type, Print)	D606275	_	TANUSAM 3	2006

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of I			t.	000	01172
		¥:	Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death								3. Time of Death
	Physici		JUSEPH WI	LLIAM	6.0	AWFONO		TA	nth Da		M
	/Medic Examin		4a. Facility Name (If not institution, give stre		02.	4b. City, Town,				County of De	
	LAGIIII	lei	HARFOND MEMOR		0. 70 4	HAURE		52465		ALFO	
	Funeral		5. Sociat Security Number 6. Sex		(In yrs. last birthday			24 Hrs. 8 Dat	e of Birth	Q R	irthplace (State or Foreign
н	Director		218-26-8413 1X M	2□F	75 Yrs.	Months Days	Hours	Min. (Mo	ot. 11,1	930	Country) Maryland
			Usual Residence of Decedent								,
	ylan		10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	Ma-f	ţō	Maryland Cecil			Pe	rryvil	lle			1 X Yes 2 ☐ No
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Ci	tizen of What (Country?
	th wi	a D	100 Greenway, Apt.	No. 420			21903			U.S.	.A.
	dea	ner	11. Marital Status 12.	Was Decedent 8 Armed Forces?	Ever in U.S. 13.	Was Decedent of It	Hispanic Ori	gin? (Specify Ye	s or No-	14. Race - An	
9	or It	by Funeral	1 ☐ Never Married 2X Married	1 X Yes 2 N If Yes, Give	lo	1 ☐ Yes 2 🖾 No			B(C.)	Black, Wh	
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or Items 23e or 28a-f show he Nedical Energiner must be notified at	d b	3 Widowed 4 Divorced	Year or Dates:]	L95 1- 54	10 103 223110	эрөспу.			Specify:	White
5	72 h	Completed	15. Decedent's Educat (Specify only highest grade c	ion ompleted)	(Give	dent's Usual Occu	durina mos	t of working		ind of Busines	
2	ithin	du	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retire	ed)	ŭ	1		al Center
2	ygier ygier yertl	S	Ten Years			Maintena					t, Maryland
Maryland	be filed within 72 hours after death with the Marylan ntal Hygiene. So dether than "neturel", or Items 23e or 28a-f show event. The Medical Examinat must be notified at	Be	17. Father's Name (First, Middle, Last)	a. Carre	F 3		18. Mothe	er's Name (First,		,	
7 2	ould Mer Marke	ို	Joseph Lawren				<u> </u>		lie D. I		
Jar	s 1 and 2 should be f f Health and Mental h Item 27 Is marked of other treumetic eve		19a. Informant's Name/Relationship (Type,			ng Address (Street			-		
	and tealth m 27 her t			Wife)		Greenway,	, Apt.		-		
Ore	ges 1 of H if ite		20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ Rem	oval from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other pla	ice)	Date	20c. L	ocation - City o	r Town, State
altimore,	Pag ment ent: ury c		' 4 □ Donation 5 □ Other (Specify)		R.A. Ferr	is & Co.,]	Inc.	01/07/0	6 West	Chester,	Pennsylvania
Ball	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is eny injury or other tre		21. Signature of Funeral Service Licensee	12 W 21	L	2. Name and Addre ee A. Pat	tterso	n & Son			P.A.
			23a. Part1. Enter the disease, or complicat	ions that caused	the death. Do not en	erryville ter the mode of dyi	ing, such as	cardiac or respire	atory arrest,	/66	Approximate
	O constant		shock, or heart failure. List only one cause on each line. Interval Between tymmediate Cause (Final Cause (F								
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a	HADLU	· .					
	Examiner			Due to (or as a	consequence on.						
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Luisease or injury	Due to (or as a	a consequence of):						
10	uted d ansit	min	cause. Enter Underlying Cause (Libeate or injury that initiated events								
1	n and	Examiner	resulting in death) Last	Due to (or as a	a consequence of):						
8760,	cate be executed physician and the burial-transit	dical									
89	ficate p phy as the	edlo									l
Вох	that the death certifined by the attending I	Physician/Me	IF FEMALE: 23c. Was decedent pregnant	If yes, outcome						23d. Date of de	elivery
	death e atte	Cla	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth : 4 Pregnant at		⊒Ectopic pregnanc ☐ Other (specify) _	У			Month	Day Year
0	the oy the	Jys	9 Unknown	9□ Unknown							
σ.	The law requires that the site has been signed by the bage 2 should be detache	by P	Part II. Other significant conditions contrib	outing to death bu	t not resulting in the t	nderlying cause giv	ven in Part I.	236	e. Did tobacco u	use contribute	to the cause of death?
Records,	quires n sign uld be	d b	SIP COROJANY	ANTO	LY BY PA	55 5024	Eng		1 ☐ Yes 2	□No 3□F	Probably 4 Unknown
00	w requires been si	Completed	ř		,	1		248	a. Was an	24b. Were a	utopsy findings available
\mathbb{R}^{e}	The law ate has page 2:	m							autopsy performed?	prior to death?	completion of cause of
Vital	(0	e C	25. Was case referred to medical						Yes 2 No	1 □ Ye	s 2(2)No
	Physicien: rthis certificaral director,	<u> </u>	examiner? 1	oital:	nt 2 @ER/Outpatie	ott	hor	of Death (Check			
of	Phys	To It		28a. Date of Injur	y 28b. Time o	" 3 DOA	4 🗀 1901	rsing Home 5 [28d, De	Scribe how injur		ecify)
Division	Attending I or death. ector: After by the funer	to	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) tnjury	Wo			,	,	
S	l or Attenc after death Director: I in by the	fica	3 Suicide 6 Could not be	28e. Place of Inju	ry - At home, farm, st				ation /Street an	d Number or F	Tural Route Number,
2	after after Direct	Certification;	4 Homicide determined	building, etc	. (Specify)	,,		City	or Town, State)	
	spite		29a. Certifier 1 ☐ Certifying Physici	an: To the best o	f my knowledge, dear	h occurred at the ti	me, date and	d place, and due	to the cause(s)	and manner a	s stated
	24 h 24 h e Fui etely	edical	(Check only 2 Madicat Examiner one)	On the basis of and manner state	examination and/or in	vestigation, in my	opinion, deat	th occurred at the	time, date and	place, and du	e to the cause(s)
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Dat	e signed (Mon	th, Day, Year)
)	->-0		Gan Like	A	ν ω Λ	0	2150	=	JAA	0424	3~12006
	41		30. Name and address of person who comp	leted cause of de	path (Item 23a) (Type		_ , 5 0	7			2006
	5/1		9-5. Praziti ms	Z 336			702	in m	N 2105	िंद	
	Sta	te	31. Date filed (Month, Day, Year)				V 37 4.		<u> </u>		
	Registr		JAN 0 4 20	ns He	Land A	South					
					and the same						

			1 - For State Registrar	State of Man		artment of H rtificate of L		-	giene	6 0	1173	
ı	Physici		Decedent's Name (First, Middle, Last) C	LAUDE NMI	CASSATT			2. Date of De Month Januar	Day	Year 006	3. Time of Death 8:00 PM	
	/Medio Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death						4c. County	c. County of Death Frederick		
	Funeral Director		5. Social Security Number 6. Sex 1気M	7. Age (li	90 Yrs. last birthday)	If Under 1 Year Months Days	If Under 24 H Hours M		th ty, Year) 1915	Countr	ace (State or Foreign Y) lexico	
	land		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				100	d. Inside City Limits	
	Mary	tor	Maryland Frederick		Frederic	ek					1 □ Yes 2√□ No	
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of \		γ?	
	eath w	Funeral	5955 Quinn Orchard	Road Was Decedent Eve	cialle 123	2170		(Casaita Vanasa Na		S.A.	- 1- 4	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland if of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28e-f show or other treumatic event, the Madical Examiner must be multified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	ł	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Spanic Origin? n, Mexican, Pui Specify:	(Specify Yes of No erto Rican, etc.)	Specify	e - America ck, White, et	tc.	
2-0	72 hor	eted	15. Decedent's Educati (Specify only highest grade co	on ompleted)	16a. Deced	dent's Usual Occupa	ition Jurina most of w	vorkina	16b. Kind of Bi			
121	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired 11wright)		General	M+11		
Maryland 21215-0036	e filed al Hygid I other vent, II	BeC	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle,				
ylaı	should be and Mental s marked o umatic eve	To E	Virgil Cassatt					etta Youn				
Mar	id 2 sh Ith and 27 is m treum		19a. Informant's Name/Relationship (Type, Ruth B. Cassatt / N	<i>Print)</i> Wife		ng Address <i>(Street a</i> Quinn Oro						
	s 1 and of Health item 27 other tr		20a. Method of Disposition	2	20b. Place of Dispo			Date Pieu	20c. Location -			
altimore,	Page ment c ent: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem `4 ☐ Donation 5 ☐ Other (Specify)	oval from State	Smithsbur	g Cremato	ry 1/4	4/06	Smithsb	urg, M	laryland	
Ball	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21. Signature of Fineral Squice Live isee	Sitt	R ²³	BEREPORTH	ATLEY &	SON FUN	ERAL HON	MES, P	°.A.	
	rnysician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									
		resulting in death)									onset and obatin	
6			Due to (or as a consequence of):									
_	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co			-					
	and al-tran	хап	resulting in death) Last Due to (or as a consequence of):							-		
68760,	icate be executed physician and s the burial-transit	edical Examine	d									
-	ertifica ding ph		IF FEMALE:	If you guttage a of -								
P.O. Box	that the death certii ed by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1							23d. Date of delivery Month Day Year		
	res that igned b	by Pł	Part II. Other significant conditions contrib	uting to death but no	ot resulting in the ur	nderlying cause give	n in Part I.		a. Did tobacco use contribute to the cause of death?			
ord	w require been si should I	eted								3 Probab	oly 4 Onknown	
Vital Records,	The tarte has	Completed	OF W.						rmed? c	prior to comp leath?	y findings available bletion of cause of	
	ysicial is certi directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hosp	oital:	2 ER/Outpatien	t 3 DOA Othe		eath <i>Check onl</i> of Home 5 Resid		ar (Snacifu)		
Division of	ing Ph Mer thi	on: T	27. Manner of Death 1 Natural 5 Pending	8a. Date of Injury (Month, Day Ye	28b. Time of	28c. Injury Work		**	ow injury occurr			
Sio	ttendi death. stor: A / the fu	catl	2 Accident investigation 3 Suicide 6 Could not be	8e. Place of Injury	At home form etre	M 1 Y	es 2□No	29f Location /6	Street and Numbe	ar ar Own I	Zavita Africa havi	
<u>></u>	ital or A	Certification:	4 Homicide	building, etc. (5	pecify)			City or Tow	n, State)			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, to completely filled in by the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, to the funeral director, the funeral director, the funeral director is the funeral director.	Medical	29a. Certifier 1 Certifying Physicia (Check only one) 2 Medical Examiner:	on: To the best of m On the basis of exa and manner stated.	y knowledge, death imination and/or inv	estigation, in my op	inion, death occ	ce, and due to the courred at the time, of	cause(s) and ma date and place, a	nner as state and due to th	ed. ne cause(s)	
	To To con	~	29b. Signature and title of certifier		Λ. Δ	29c. License			29d. Date signed	(Month, Da	y, Year)	
	5		30 Name and address of person — o compl	eted cause of death	(Item 23a) (Type I	036	,	1	1141	2006		
			James Amerena	13000	Ridgefi	eld D. #	104	Frederin	ck MD	217	101	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 5 200	32. Redistrar's	Signature J	beet						

DHMH 17 Rev 1/2001

HOLLY J. CAREY 06-00195 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27,28a-f,pen/E,0851,1/21/06 IT State of Maryland / Department of Health and Mental Hygiene RKD 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 8, JANUARY 7:07A Holly Jo Carey 2006 /Medical 4a. Facifity Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALISBURY

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthpiece Country)

August 23, 1968 | Pelaware 334 BARCLAY STREET 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🖺 F 37 Yrs. Director 216-90-0947 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f ehow rectified at 1 ☐ Yes 2 ☑ No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò other than "natural", or items 23s or vent, the Medical Examinar must be 27480 Waller Rd. 21801 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ff Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Holly & Jamie's College (1-4or 5+) 12 Cleaning Service Cleaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irvin Garland Kennedy Josephine Elizabeth Whaley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irvin Kennedy/father 27480 Waller Rd. Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Salisbury Crematory 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/11/06 Salisbury, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee Holloway Funeral Home P.A. CFSP 501 Snowhill Rd. Salisbury, MD 21804 Socialoge 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Intervaf Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** Methadone Intoxication /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, and saying to mind a sequentially cause. Enter Underlying Cause (Disease or injury that in Disease or injury that in the sequential seq Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) ed by the e 1 Yes 2 No 9 Unknown 9 Unknown s been signed b should be dete Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ∭Unknown 1 Yes 2 No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s autopsy certificate 1 Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Pface of Death (Check only one) Hospitaf: 1 ☐ fnpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE 2 1t∏ Yes 2 No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury Fnd (Month, Day Year) 28b. Time of Fnd After thi funeral 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation deeth. i Director: A 1 ☐ Yes 2 No 1/8/2006 6:50 A 2 Accident 6XXCould not be 3 🗌 Surcide 28f. Location (Street and Number or Rural Route Number City or Town, State) 334 Barclay Street 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 - Homicide within 24 hours after To the Funeral Dire Salisbury, MD Found at shelter 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

JAN 1 2 2006

32. Registrar's Signature

m. D

mis

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

March G. Spark

O.C.M.E.

JANUARY 9, 2006

111 PENN STREET BALTIMORE, MARYLAND 21201

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

					State of Ma	aryland /	Certificate		і менаі пу	Reg. No.	16	01175	
	Dhorisi		1. Decedent's Name (First, Middle, Last) 2. Dete of Deel Month						Dey	Year	3. Time of Death		
1	Physici /Medio	ai -	Ethel (nmn) Cornish					Jan.		006	10:40 AM		
, i	Examir	er			street and number)			4c. County of Death Williamsport Washington					
			5. Social Security N		sing Home	je (In yrs. last l	birthday) If Under 1	ear If Under 24 H				place (Stete or Foreign ntry)	
	Funeral Director		220-16-0050 10 Yrs. 10/22/1905							Cou	PA		
	/lend	ı	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Washington Hagerstown									10d. Inside City Limits	
	Man and and and and and and and and and a	ţ	MD Washington Hagerstown 10e Street and Number 10g. Citizen of What C								1½ Yes 2 No		
020	h with the 23a or 28	Funeral Director	10e. Street end Number 300 Cornell Avenue							10g. Citizen of W US	Vhat Cou	ntry?	
	within 72 hours efter death with the Marylend ene. than "natural", or frems 23a or 28a-f show the Madical Examiner must be notified at	<u>\$</u>	11. Marital Stetus 1 ☐ Never Marri 3 ☑ Widowed	ed 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Detes:	?	13. Was Deceden If Yes, specify 1 □ Yes 2	t of Hispanic Origin? Cuban, Mexican, Pu No <i>Specify:</i>	(Specify Yes or Nerto Rican, etc.)	o- 14. Race Blac Specify.	k, White,	can Indien, .etc. nite	
5-0	72 hc	Completed	(Spec	15. Decedent's Ed		16	Give kind of work	occupation Sone during most of valued)	workin g	16b. Kind of Bu	isiness/Ir	ss/Industry	
72	within ene.	E G	Elementary/Seco	ndary (0-12)	College (1-4or	5+)		state Bro	_	D _c	aa 1 1	eal Estate	
9	e filed v el Hygie other t vent, tr		17. Fether's Neme	(First, Middle, Last)	4		Real F		Name (First, Middle			Estate	
an	Mentel Mentel arked o	To Be	Frank (u	ınk) McKo	sky			(unk)					
Baltimore, Maryland 21215-0020	end end is m			ame/Relationship (Type Print) / Pers. R		9b. Mailing Address (S 3237 Fount						
re,	Heal the t		20a. Method of Disp	position		20b. Place	of Disposition (Name stery, crematory or other	of or place)	Date	20c. Location -	City or T	own, State	
Ë	Pages nent of I int: If ite ury or o	- 1	1 ☐ Burial 2 ☐ 4 ☐ Donation	☐ Cremation 3 ☐ 5 ☑ Other (Specifi	Removal from State Entombmer		Haven Cem		1/11/06	Hagersto	own,	MD	
Balti	permit. Page Department of Important: If any Injury or pnce.		21. Signature of Fu			2	22. Name and					neral Home 21740	
	3.00		23a. Pert1. Enter t	he diseese, or com	plications that cause one ceuse on each I	d the death. C	o not enter the mode of	of dying, such as card	diac or respiratory	arrest,	1	Approximate Interval Between	
	Physician /Medical		Immediate Cause	(Final			000	00 00 0				Onset and Death	
	Examiner		disease or condition resulting in deeth) e. Spiration pneumonia Week Due to (or es e consequence of):										
	sertificate be executed ding physician end see st the burial-trensit	/Medical Examiner	Sequentially list co if eny, leeding to in ceuse. Enter Unde Cause (Disease or that initiated events resulting in death)	5	b. Alzh.	Due to (or es	e consequence of):	ise with	dysph	agia		years	
Вох	leath certi attending d for use e	clar	D 411 000 1	et	en eiven in Port I	23h Die	i tobecco use co	ntribute	to the cause of death?				
P.O.	res thet the de signed by the a l be detached (hysi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							1 Yes 2 No 3 Probably 4 Unknown			
	s thet gned to se det	y P	Chronic	obstru	ctive lu	ng d	iscase		_				
of Vital Records,	requi	Completed by Physician/M								Vas an autopsy erformed? 24b. Were autopsy finding available prior to completion of cause of death?			
Re	tysician: The law his certificate hes b I director, page 2 s	Eo							42	Yes 22 No	1	□Yes 2□No	
ita		BeC	25. Was case refe	rred to medical					Death (Check only	one)	1		
*	Physician: this certific	To	examiner? 1 ☐ Yes 2 ☐	No	Hospital: 1 Inpat	ient 2 ER	/Outpatient 3□ DOA		ng Home 5 ☐ Re	sidence 6 □Oth	er (Spec	rity)	
ion o	← ← 9		27. Manner of Death 1 Staturel 5 Pending (Month, Day Year) 2 Accident investigation					: Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	e how injury occur	red		
Division	after de Directo d in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286. Place of It	njury - At home etc. <i>(Specify)</i>	, farm, street, factory,	office		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)	1. Certifying Pt 2 Medical Exam	nysician: To the bes miner: On the basis end manner s	of examination	dge, deeth occurred at end/or investigation, in	the time, date and pl n my opinion, death o	lece, and due to the	e cause(s) and ma e, date and place,	anner as and due	steted. to the cause(s)	
	Vithin To the	Z	29b. Signature end	title of certifier			29c.	icense number		29d. Date signe	d (Month	n, Day, Year)	
			Cynd	Ria Ku	ther-s	sands	I an	147451		Januari	4 5,	2006	
	07		30. Name end edd	ress of person who	completed cause of	death (Item 23	Be) (Type, Print)	+ Nursing	Home	154 No	rth	Artizan 21795	
100	St	ate	31. Date filed (Moi	nth Day, Year)	32. Régis	trer's Signeture	8 1		MAPON	, , , , , , , , ,	101		
	Regist	29b. Signature end title of certifier Cynthia Kuther-Sands no D47451 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Cynthia Kuther-Sands no Williamsport Nursing Home 154 North Arrisan Many I and 21795 State 31. Date filed (Month) Day, Year) 32. Registrer's Signeture State State State											

DHMH 16 Rev 6/95

			1 - For State Registrar	State of M	larylan	-	artmeni rtificate				-	giene Reg. N o.	11116	011	76
	Dhuaisi		1. Decedent's Name (First, Middle,	Last)							2. Date of De Month			3. Time of	Death
	Physici /Medic		JULIUS CONISON					JANUARY 1, 2006 8:30						AM	
	Examin	er	4a. Facility Name (If not institution,	give street and number)				Location o	of Death			County of Dea		
			15121 GLADE DRIVE 5. Social Security Number 6	. Sex 7. A	ne (In urs	last birthday)	If Under	ER SI	If Under:	24 Hrs.	8. Date of Bir		ONTGOME	rthplace (State of	Ci
	Funeral Director		272-14-3109	1₽M 2□F	84	Yrs.	Months	Days	Hours	Min.	3/1/192	Year)	3. 6	OHIO	_
	D		Usual Residence of Decedent												
	arylar show	ڀ	MARYLAND MONTGOM	EDV		y, Town or Lo								10d. Inside C	
	Ba-f	Director													2 🛛 No
	with I						10f. Zip						izen of What C	country?	
	ns 23	Funerai	15121 GLADE DRIVE	12. Was Deceden	t Ever in U	S. 13.		906 lent of Hi	spanic Orig	inin? (Spe	cify Yes or No	US.	A 14. Race - Am	erican Indian	
39	d within 72 hours after deeth with the Maryland jeen. r than "natural; or Items 23a or 28a-f show I'ne Medical Evanther must be molified at	þ	1 □ Never Married 2 □ XMarried 3 □ Widowed 4 □ Divorced	Armed Forces 1 □XYes 2 □ If Yes, Give	1 🛣 Yes 2 🗆 Notatat T		lf Yes, spec 1 ☐ Yes 2	adent of Hispanic Origin? (Specify Yes or No- ecify Cuban, Mexican, Puerto Rican, etc.) 2 🖾 No Specify:				Black, White, etc. Specify: CAUCASIAN			
2-0	72 ho	eted	15. Decedent's (Specify only highest	Education		16a. Dece	dent's Usual Occupation kind of work done during most of working				10	16b. Ki	nd of Busines	s/Industry	
21215-0036	within liene.	Completed	Elementary/Secondary (0-12)		College (1-4or 5+)		DO NOT us	D NOT use retired) ED PUBLIC ACCOUNT				COOLINETA			
	e filed v Il Hygie other t		17. Father's Name (First, Middle, La	et)		CERTIF	IED PU	DEIC			(First, Middle		CCOUNTIN	G	
and	d be filed antal Hyg ced othe c event,	To Be	ISRAEL COHEN	31)					16. WOULE	JENN]			Sumamej		
Maryland	permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked 1 any injury gaether traumatic av once.	-	19a. Informant's Name/Relationship ANNETTEE CONISON/W							er or Rural		er, City o	r Town, State,	Zip Code)	
Baltimore, I	of Healt of Healt if item 2		20a. Method of Disposition 1 🛱 Burial 2 ☐ Cremation 3	□ Removal from State		Place of Dispo	sition (Nan	ne of			ate		ocation - City o	r Town, State	
ţ	t. Pag tment tent:		`4 □ Donation 5 □ Other (Spe	cify)	JUD	EAN MEMO				1/2/2			NEY, MD		
Bal	Depar Depar Impor any ir		21. Signature of Funeral Service Lie			22	2. Name and 11800 I	d Addres NEW H	s of Facilit	HINE RE AVE	ES-RINAL E; SILVE	DI FU	NERAL HO ING MD 2	ME 0904	
			shock, or heart failure. List only one cause on each line.											Approximat Interval Bet	tween
F	Physician /Medical		Immediate Cause (Final disease or condition a. NONHODGKINS LYMPPOMA resulting in death)								1 YEAR	Deau			
	Examiner		Due to (or as a consequence of):												
н		Je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):												
	cuted nd ransit	Examine	cause. Enter Underlying Causa Ciscasa or mysty that initiated events c												
Ő,	e exe	EX	resulting in death) Last Due to (or as a consequence of):												
8760,	cate be executed physician and the burial-transit	dicai		d											
9		O I	IF FEMALE:	23c. If yes, outcom	e of pregna	ancv					77		204 Date -44	1	
Вох	death certifi e attending id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1☐Live birth	1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 □			□Ectopic pregnancy □ Other (specify)				23d. Date of delivery Month Day			Year
o.	0 0 0	hysi	9 Unknown	9□ Unknown			(0,5								
S, D	requires that the een signed by th hould be detache	by P	Part II. Other significant condition	s contributing to death	but not res	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did t	obacco u	ise contribute	to the cause of	death?
rd	w require been sig shoufd b										1 🗆	Yes 2	∑No 3□F	robably 4 🗍	Jnknown
Record	law as b	ompleted									24a. Was		24b. Were a	utopsy findings completion of c	available
<u>~</u>	The cate has page	Con									perfo	rmed? 2 ☑ No	death?	s 2□No	
Vital	Physician: 'this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:				Oth			(Check only o				
of		. To	1 Yes 2 No 27. Manner of Death	28a. Date of In		ER/Outpatier 28b. Time o		8c. Injury			ne 5 ☐Resi 8d. Describe		6 □Other (Sp	ecify)	
OU	Attending Ir death. ector: After by the funer	tlon	1 Natural 5 Pending 2 Accident Investiga	(Month, D	ay Year)	Injury	м	Worl	ດີີ່ Yes 2.∐l		00. 2030120	iow anjur	y occurred		
Division	I or Attendi after death. Director: A I in by the fu	ertification:	3 Sutcide 6 Could no determin	t be 28e. Place of Ir			reet, factory	, office		2				Rural Route Nurr	nber,
Ö	in Siring	Cert	4 Homicide	building, e	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					City or To	vn, State)			
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1	Physician: To the best saminer: On the basis and manner s	of examina	wledge, deat ition and/or in	h occurred a vestigation,	at the tim in my of	e, date an pinion, dea	nd place, a oth occurre	nd due to the	cause(s) date and	and manner a place, and du	s stated. e to the cause(s	s)
	To th withir To th comp	Me	29b. Signature and title of certifier				29c	. License	number			29d. Dat	e signed (Mor	th, Day, Year)	
)	6		> much	wor RM				D245	43			JANI	UARY 1,	2006	
			30. Name and address of person w		death (Iten	п 23а) (Туре,	Print)						·		
			JAMES A. ROSSI M.D. 31. Date filed (Month, Day, Year)					LVER	SPRING	MD 20	906				
	Sta Registi	_		2006 324 legis	uars signa	ture do	ede								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** RALPH JOSEPH CARTENZENDAFNER 4, JANUARY 2006 11:32 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** CIVISTA MEDICAL CENTER PLATA CHARLES LA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F Yrs. Director 86 OCT.11,1919 MARYLAND 215-01-6660 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show the Medical Examiner - set be notified at W yes 2 □ No Director MARYLAND CHARLES LA PLATA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Items 23a 20646 219 STARKEY COURT U.S.A. Be Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Heatih and Mental Hygiene. Int: If item 27 is marked other then "netural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? M∑X'es 2 □ No if Yes, Give Year or Dates: WW∏∏ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 💢 No Specify XWidowed 4 □ Divorced WHITE 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) REA & DEPT. OF College (1-4or 5+) Elementary/Secondary (0-12) AGRICULTURE 12 CHEIF ELECTRICAL ENGINEER other treumatic event, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOSEPH CARTZENDAFNER 2 LAMORA FINK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CHRISTOPHER CARTZENDAFNER-GR.SON 5216 DALTON RD., SPRINGFIELD, VA 22151 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial \$ ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) MET ö permit. Page Department of Importent: If any injury or once. METROPOLITIAN CREMATORY 01-09-06 ALEXANDRIA, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Minutes /Medical Due to (or as a consequence of): Examiner ardismyopathy, Dilated Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or). Examiner itation due to Mira Valve - rol ase The law requires that the death certificate be executed Require nitral that initiated events resulting in death) Last Due to (or as a con - uence Box 68760, Resursitation and Hypertensis, Completed by Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy jo Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f ☐Yes 2☐No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sothyroidism, Grou 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 014,20515 autopsy performe 1 Yes 1 Yes 2 No 2 No of Vital Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Cther: 1 ☐ Inpatient 2 ☐ ER/Outpatient DOA 4 Nursing Home 2 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Certification: Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: in by the 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 T Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medicel Exeminer: On the basis of examination and/or investigation in my online.] 29a Certifier ical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year)

9+1

State Registrar GOPALAKRISHNAN 31. Date filed (Month, Day, Year) JAN 1 8 2006

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D-046345

2006

		ļ	State of	Maryland / Depa		alth and Mo	ental Hygie	2006	01178			
			Registrar 1. Decedent's Name (First, Middle, Last)	Cei	Tillicate of D		Reg. 2. Date of Death	No.	3. Time of Death			
	Physicia	an		DEV			Month	Day Year				
	/Medic		MARGARET ANNE CA 4a. Facility Name (If not institution, give street and num	REY	4b. City, Town, or L		Jan. 5,	5, 2006 1:02 A ^M				
	Examin	er			Berlin	OCATION OF DOGIN		Worceste				
	Francis		10314 Old Ocean City Blv 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye		thplace (State or Foreign ountry)			
	Funeral Director		164 28 8991	70 Yrs.	Months Days	Hours Min.	(Month, Day, Ye Sept 10,		ennsylvania			
	ס		Usual Residence of Decedent				Sept 10,		•			
	irylar show		10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits			
	Ba-f	cto	Maryland Worcester	Berlin					Yes 2 No			
	vith th	5	10e. Street and Number	-	10f. Zip Code			Citizen of What C	ountry?			
	s 23s	ra	10314 Old Ocean City Blv		21811	- 1- O-1-1-0 (O		.S.A.	- incoloration			
	er de Item	nu.	Armed For	dent Ever in U.S. 13.1	Was Decedent of Hisp If Yes, specify Cuban,	Mexican, Puerto F	Rican, etc.)	14. Race - Am Black, Whi				
36	rs aft	by F	1 Never Married 2 Married 1 Yes 3 If Yes, Give 93 Widowed 4 Divorced Year or Da	0	1□Yes 2X No	Specify:		Specify: W	nite			
Ö	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ehow ta Medical Exactinat maril to notified at	Completed by Funeral Director	15. Decedent's Education	16a. Dece	dent's Usual Occupati	ion	166	. Kind of Business	/Industry			
215	hin 7.	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	-4or 5+) (Give	kind of work done dua DO NOT use retired)	ring most of workin	ng					
2	d with	mo:	11		hier			Grocery S	Store			
g	al Hygie I other vent, II	Be (17. Father's Name (First, Middle, Last)		1	8. Mother's Name	(First, Middle, Mai	den <i>Sumame)</i>				
<u>la</u>	should be to and Mental is marked our umatic ever	Tol	William Bonard McCurdy			Mary Lynch und Number or Rural Route Number, City or Town, State, Zip Code)						
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exact read to notified at once.		19a. Informant's Name/Relationship (Type, Print)									
	l and lealth im 27 her ti	0.0	Richard V. Carey		4 Old Ocea			erlin, MI Location - City or				
5	Pages nent of hant; if the		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from S		osition (Name of matory or other place)							
altimore,	t. Pa rtmer rtant: rjury		4 ☐ Donation 5 ☐ Other (Specify)	and the second second	en Cemetei			erlin, MD				
Ba	permit. Departr Importa any inji		21. Signature of June of Service Licensee		2. Name and Address he Burbac			108 Willia Berlin M				
			23a. Part1. Enter the disease, or complications that ca						Approximate			
1	Second Second		shock, or heart failure. List only one cause on each line.									
	Pnysician /Medical		disease or condition resulting in death)	or as a consequence of):	ma or the	Lung			5 Months			
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	cuted Id ransit	Examiner	Cause (Disease or injury that initiated events									
Ó	e exerian ar	EX	resulting in death) Last Due to (d	or as a consequence of):								
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	lical	d									
9	artifica ing ph e as tl	Mec	IF FEMALE:			528.0		23d. Date of delivery Month Day Yea				
Вох	eath certific attending p I for use as	ian/	23b. Was decedent pregnant 1 Live bi		Ectopic pregnancy							
<u>.</u>	at the de by the a tached f	Physician/Med	1 ☐ Yes X☐ No 4 ☐ Pregna 9 ☐ Unknown 9 ☐ Unknown		Other (specify)			-				
P.0.	that the ed by detac		Part II. Other significant conditions contributing to de	eath but not resulting in the u	inderlying cause given	in Part I.	23e. Did tobac	tobacco use contribute to the cause of death?				
ds,	uires tha signed d be del	d by	Chronic Obstructive Lu	na disease			1 🔀 Yes	2 □ No 3 □ P	robably 4 Unknown			
COL	w requir been si should	iete	Diabetes				24a. Was an	24b. Were a	utopsy findings available			
Records,	The lav	Completed					autopsy performed	autopsy prior to completion of cause of performed? death?				
Vital	ilcian: Th certificate ector, paç	e Cc	Hypertension 25. Was case referred to medical			26. Place of Death	(Check only one)	No 1 Ye	s 2 No			
		0 8	examiner?	npatient 2 ER/Outpatie	Other		ne 5 🔀 Residence	e 6 ∏Other (Spe	acity)			
o	g Phys er this ieral di	n: T	27. Manner of Death 28a. Date of	of Injury 28b. Time of Injury	100.00	A SALE OF THE PARTY OF THE PART	8d. Describe how i					
jo	Attending F r death. ector: After by the funer	atio	2 Accident investigation	,, 54, 7, 64, 7		es 2□No						
Division of	l or Attenuafter deatl Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place buildir	of Injury - At home, farm, str ng, etc. (Specify)	reet, factory, office	2	28f. Location (Stree City or Town, S		tural Route Number,			
	urs aft ral Di											
	Hosp 14 hou Fune tely fil	icai	29a. Certifier (Check only 2 Medical Examiner: On the ba	asis of examination and/or in								
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medicai	one) and mann 29b. Signature and vitle of certifier	iei stated.	29c. License r	number	29d.	Date signed (Mon	th, Day, Year)			
}	F 3 F 8		· C/C/V/			0690	1	uary 6,				
•			30. Name and address of person who completed cause	e of death (Item 23a) (Type	Print)	- 67G						
)	H. 6		30. Name and address of person who completed cause of the state of the	145 E	- Correl	1 51	Solis	burn	MO.			
	Sta	itė	31. Date filed (Month, Day, Year) 32 JAN 0 6 2006 32	egistrar's Signature	hards 3		1	//				
	Regist	ar	JAN U O ZUUB	we is 19								

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 10, 2006 Pauline Alberta Chanev 12:40P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Harbour Health Center Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1□M 2**⊠**F Washington, D.C Director 83 578-20-4255 9-17-1922 Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene. other than "natural", or Itsms 23a or 28e-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itsms 23s or 28e-f show the Medical Examinar must be notified at by Funeral Director Washington DC XIXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 1339 S Street 20020 S.E. USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Secretary 17. Father's Name (First, Middle, Last) Peges 1 end 2 should be fill ment of Heelth and Mental Hitam 27 is marked other. 18. Mother's Name (First, Middle, Maiden Surname) Be Philip Spencer Cusic 2 Ola Bane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth a important: If itsm 27 is sny injury or other training once. Stanley L. Chaney/Son 3128 Stonehenge Dr., Riva, Maryland 21140 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dale Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/13/2006 Cedar Hill Cemeterv Suitland, Maryland 21. Signalur of Funeral Pervice/Licensee 22. Name and Address of Gelbrge P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part VEnier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** browns when /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed anding physicien end use as the burial-translt Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai ed by the ettending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at lime of death 5 Other (specify) 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 212 No 1 Yes 2 No 1□ Yes To the Hospital or Attending Physician: Be funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification; To 1 ☐ Yes ZXNo 1 🗌 Inpatient 2 ER/OutpatienI 3 DOA 28a. Dale of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Secretifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of pertitle 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Da lest Sunch 31. Dale North, Day, Year Clen Burne MD 21061 208 Crain Highway 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Month Year Louis Ciarrocchi Januarv 2006 5:42 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Gilcrest Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Months 1**X**XM 2□ F Yrs 159-05-3839 89 Aug. 6,1916 Pennsylvania Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County 1 Yes 2X No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10804 Terrier Court 21044 USA 12. Was Decedent Ever in U.S. Armed Forces? XXX/es 2 □ No If Yes, Give Year or Dates: WWI Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes XXNo Specify: WWII White 3XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 4 Electrical Engineer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Guido Ciarrocchi Marie A. Salera ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Ciarrocchi (Son) 10804 Terrier Court, Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 NOther (Specify)Entombment St. Peter's Mausoleum 1-4-2006 Riverside, New Jersey 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Jarline Immediate Cause (Final Cen 923 ear disease or condition resulting in death) Due to (or as a consequence of)

Physician /Medical Examiner

attending physician and for use as the burial-transit

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within 24 hours after death. To the Funerel Director: A

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Completed

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Certification:

Medical

The law requires that the death certificate be executed

Hospitel or Attending Physicien:

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Physician

/Medical

Examiner

Funeral

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ral', or Items 23a or 28a-f ahow Examiner must be notified at

"natural"

12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "r

Health Item 27 I

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Important: If Its any injury or o once.

filed within 72 hours after death

2121

Maryland

Baltimore,

Director

Completed by Funeral

Examine

Due to (or as a consequence of) Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 2 Fetal death 4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

24a. Was an autopsy performed? 1 ☐ Yes 2 121 No 26. Place of Death | Check only one

28d. Describe how injury occurred

2 No 1 Yes

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

27. Manner of Death 5 Pending 1 Natural

investigation 6 Could not be determined

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Stother (Specify) Hospite 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

2 Accident

3 Suicide

4 Homicide

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

les SI: Balto md

29b. Signature and title of certifier

29c. License number 25205

January 1, 2006

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause death (Item 23a) (Type, Print)

6701

State Registrar

31. Date filed (Month, Day, Year)



no

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Rag. No. Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 3 Month Year 0130 M JANUARY 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death legional medical ninsula Center WILLOWILL 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Days Months Hours M 2□ F 138-56-8396 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ACCOMAC 1 Yes 2 No ocustville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23 464 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) ted 7412 States 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No. If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Aboren 10 unstruction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HAYS THE Conquesi 19a. Informant' Name/Relationshic (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAther NO mother 27412 DRummenttown 20c. Location - City or Town, State Cenquest 20b. Place of Disposition (Name of cametery, genatory or other place) Nedab Date 20a. Method of Disposition Surial 2 ☐ Cremation 3 ☐ Removal from State 7-06 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Pupton 22. Name and Address of Facility WHARTEN Sharlow 9 6 K_{ℓ} 22171 WhARton Ad A CCOMAC VA 23301 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nepatocellular Immediate Cause (Final carcinoma disease or condition resulting in death) Due to (or as a consequence of): Esquentially list or differs, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last uence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Directo

by Funeral

Completed

Be

Funeral

Director

item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, In Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: if item 27 is marked other then "nat any injury or other traumatic event, it is Medica 2006.

Baltimore, Maryland 21215-0036

Examine ed by the attending physician and detached for use as the burial-transit Physician/Medical rthis certificate has been signed iral director, page 2 should be det ð ted Comple Director: After this certific Be ၉ Certification: death.

IF FEMALE

Medical

23b. Was decedent pregnant

9 Unknown

in the past 12 months?

alcohol

45C

The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

or Attending Physician:

the state of

within 24 hours after To the Funeral Direc

tr.	nepatitis C
	Due to (or as a consequence of):
c	-
	Due to (or as a consequence of):
d.	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performe 1 Yes 2 No 26 Place of Death (Check only o

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

25. Was case referred to medical	The second secon	26. Place of Death (Check only one)							
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 □ ER/Outpatient	3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify							
27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28d. Describe how injury occurred Work? M 1 1 4 2 1 No							

2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Location (Street and Number or Rural Route Number, City or Town, State)

2180 4

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of out ther 29d. Date signed (Month, Day, Year)

30. Name an Modress of person who completed cause of death (Item 23a) (Type, Print)

40059368

Salishum

MO

1/3/06

100 E. Carroll /chh Paul

31. Date filed (Month, Day, Year) State JAN 0 5 2006 Registrar

29a. Certifier

32. Registrar's Signature Bowl DONNA COLLINS Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27,28a-f, pen/E, 9853,3/9/06 TI State of Maryland / Department of Health and Mental Hygiene 06-00292 RJ Certificate of Death Reg. No." 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** January IZ, 2006 3:57 a. м COLLINS DONNA J0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Worcester County Atlantic General Hospital Berlin If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X F Yrs. Director 222-40-8158 41 NOV. 1964 10, MARYLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location or 28a-f show 10a State 10b. County 10d. Inside City Limits MARYLAND WORCESTER 1X Yes 2 No OCEAN CITY 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ ō ral', or Itams 23a or Examiner must be 14301 SINEPUXENT AVE. #5 21842 USA filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ WHITE 3 ☐ Widowed 4 X Divorced "natural" 16a. Decedent's Usual Occupation ieted the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done di life. DO NOT use retired) Compi Elementary/Secondary (0-12) College (1-4or 5+) FOOD & BEVERAGE MANAGER RESTAURANT 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental I Pages 1 and 2 should be EDWARD BAKER J. ဥ SHIRLEY BUNTING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heelth a Item 27 I SHARON K. SMITH/SISTER 11332 BACK CREEK ROAD, BISHOPVILLE, MD 21813 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Depertment of H Important: If Ite any Injury or ot once. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY OF DELMARVA 1/15/06 DELMAR, DELAWARE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Mixed drug (Acetaminophen, Zolpidem, HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Diphenhydramine) /Medical Due to (or as a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown ed by the Division of Vital Records, P.O. 9 Unknown sete has been signed page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

12 Yes 2□ No 24a. Was an autopsy performed? Yes 2 🗆 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA N Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; After 1 Natural 5 Pending efter death. I Director: Af d in by the fu 1 ☐ Yes 2 ☐ No investigation Fnd 1/12/2006 Fnd 3:00A^M 2 Accident unk 6 A Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1301 Sinepuvent Ave. #5 Ocean City, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitel of within 24 hours en found at residence 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Medical

31. Date filed (Month, Day, Year) JAN 1 7 2006

29a. Certifier

(Check only one)

29b. Signature and title of certifie

TISIU CO

32. Registral's Signature B. Sparker

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street

29c. License number OCME

29d. Date signed (Month, Day, Year)
January 13, 2006

Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Cecil /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Alleganu Social Security Number 6. Sex and PITAL If Under 24 Hrs. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 XF Months Davs Hours Oct 15. 214-52-2092 76 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nant of Heatth and Mental Hygiene.
ant: If Item 27 is marked other then "naturel", or Items 23a or 28a-1 shov ury or other traumatic event, the Medical Examinar must be notified at Allegany MD Cresaptown Completed by Funeral Director 1 X Yes 2 □ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 13709 Brant Road USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white 3 Nidowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Seymour Newton Radcliff Luella (Mick) Radcliff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RR 3 Box 3234 Keyser WV 26726 19a. Informant's Name/Relationship (Type, Print) daughter Peggy Kimble 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rocky Gap Veterans Cemetery 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State permit. Page Department of Important: If any injury or once. 1/17/2006 **Flintstone** MD 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service License ^{22. Nam}Sand Addins Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Ester the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Monic Obstructie **Physician** OYEAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine anding physicien and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical attending p for use as IF FEMALE If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9□ Unknown Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Carlure hronic intersti Rospival 1 Pres 2 □ No 3 ☐ Probably 4 ☐Unknown Coronary 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificete 2 No 1 ☐ Yes After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 Umpatient ٩ 1 | Yes 2 46 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide nin 24 hours of the Funerel Dire hours after 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0

State Registrar

31. Date filed (Month, Day, Year) JAN 1 8 2006

Musan

Husam Semaan

MI 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sacred Heart Hospital Cumbercaud MD 21502

D5620

January 12

		-	- State Registrar Amend Item		aryland / Dep I g852 2 9 9				ind Mental I	Hygien	11116	0118
Phy	ysicia	n	Decedent's Name (First, Middle, Last)	,					2. Date o	D	^{ay} 2006 ^{Year}	3. Time of Death 22:57 Р м
, /N	ledica amine	al -	4a. Facility Name (If not institution, give Harford Memorial					Location of			c. County of Dea Harfor	ith
Fund Direc			ZZ4-34-0339	x 7. Ag XM 2□F	e (In yrs. last birthday 83 Yrs.) If Under Months		If Under 2 Hours	Min. 8. Date o	f Birth Day, Year 2, 19	9. Bit 22 Nor	rthplace (State or Foreig ountry) th Carolina
Maryland	lied at	tor	Usual Residence of Decedent 10a. State 10b. County MD Harfo:	rd	10c. City, Town or L Havre de		e					10d. Inside City Limits
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Z 2 2 2	- N	To Be	17. Father's Name (First, Middle, Last) Frank Davis					Molly	r's Name <i>(First, Mic</i> y Shelton	L		
es lan of Heal	5		19a. Informant's Name/Relationship (T) Linda Marie McDo 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ F	well (Daug	ghter) 190 20b. Place of Disp cometery, cre	9 Cap	pel I	Manor	Date	ginia 20c. 1	Beach,	VA 23456 Town, State
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	page 2	Completed	Coronan	y art	ery c	hse	as		a	Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of s 2 \sum No
	ector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2 🗆 ER/Outpatre	00.00	Othe	200	of Death Check of			
5 £ \(\frac{1}{2}\)	76	⊢ ⊦	27. Manner of Ceath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju	ry 28b. Time		8c. Injury Work				ury occurred	эспу)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After	lled in by t	Certification:	3 Suicide 6 Could not be determined	building, et					City or	Town, Stai	re)	lural Route Number,
the Hosp. iin 24 hou the Funer	npletety fil	edical	(Check only 2 Medical Exemi	sicien: To the best iner: On the basis of and manner sta	of my knowledge, dea examination and/or inted.	nvestigation	, in my or	oinion, deat	d place, and due to th occurred at the ti	me, date ar	nd place, and du	e to the cause(s)
	noo	2	29b. Signature and title of certifier	Br			License	t7	746	29d. D	ate signed (Mon	
10+			30. Name and address of person who c Thomas Burke, MD				NC	II-			MD 24.05	70
	Sta		31. Date filed (Month, Day, Year)	32. Registr	01 South U	THOU F	100	na\	ite de Gr	ace, I	ישי בועי	0

Robert DAVIS

State of Maryland / Department of Health and Mental Hygiene Amended, 1 & 17 1 - For State Registrar M.D. &F.H., TCHD/01/10/2006, Sertificate of Death 2. Date of Death 3. Time of Death Day 5 **Physician** Month Trancis Dagenais January 7:00 3006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Baltimore Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month) Days, Year) MAY 9, 1940 Sex M 2 F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** MARYLAND 215-36-0097 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD. DORCHESTER HURLOCK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6626 ELWOOD ROAD 21643 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🛣 No þ Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Heatin end Mental Hygiene. Important: If Item 27 Ie marked other than any injury or other treumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 MINISTER RELIGION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIS F. DAGENAIS-II MINNIE DAVIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIAN ANN DAGENAIS/ WIFE 6626 ELWOOD RD. HURLOCK, MD. 21643 20b. Place of Disposition (Name of 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State CHESAPEAKE CREM. CTR. 1-9-06 STEVENSVILLE, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Steatohepatitis - alcoholic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physicien The taw requires that the death certificate be Physician/Medicai IF FEMALE: esn esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy be detached for Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred or Attending 1 Natural Injury 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funerel Hospitei **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 N. Greene Street, Baltimore, MD Ericson M.D. 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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/Medi	cal		Januar		006 6:15	Рм
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Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8.	Date of Bir	th v. Year)	Birthplace (State or F Country)	² oreign
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perrit. Pages 1 and 2 should Department of Health and Men Impertant: If item 27 1s marke any injury or other treumatic.		19a. Informant's Name/Relationship (Type, Print) Connie W. Larrimore/Daughter 19b. Mailing Address (Street and Number or Rural R 313 E. Central Ave.				1632
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F 3 F 8		29b. Signature and title of certifier DOOGIL88			106	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
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	/Medic Examin		Ampacility Name (If not institution, give s	.(.11	ke	Sa		144		4c. County	-	nico
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9	death cartificate e attending phys ed for use as the	Physician/Medical	IF FEMALE:	00. 1					<u>. </u>					
Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live t	tcome of pregnand pirth = 2 □ Fetal d nant at time of dea	leath 3	Ectopic pre					230	d. Date of delivement Month	ery Day Year
Ö	at the de by the tached	yslc	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkn		un 5_	Other (spe	спу)						
σ.	de de	by Ph	Part II. Other significant conditi	ons contributing to d	eath but not result	ing in the ur	ndertying car	use give	en in Part I.		23e. Did to	bacco use	contribute to t	he cause of death?
rds	quires an signa uld be										1 🗆 Y	es 2 🔀	No 3□Proi	bably 4 Dunknown
000	law requires as been sign 2 should be	plet									24a. Was a		24b. Were auto	opsy findings available impletion of cause of
Vital Records,	The ate h	Completed									perfor	med?	death?	2 X No
/ita	Physicien: The this certificate ral director, pages	Be (25. Was case referred to medica examiner?	1				0.5		of Death (Check only o	10)		
of	Phys this al dii	2	1 ☐ Yes 2 No 27. Manner of Death		Inpatient 2 El	R/Outpatien		-	4 🔲 190		e 5 Resid		Other (Speci	(y)
		tlon	1X Natural 5 ☐ Pendi	ng (Mon	of Injury 2 th, Day Year)	Injury	M	lc. Injury Work	rati ∢? Yes 2.⊟1		d. Describe II	OW III)diy C	70Cu119G	
Division	Attending r death. actor: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	of Injury - At hom	ne, farm, stre	eet, factory,	office		28			Vu <i>mber or Run</i>	al Route Number,
Ö	s after d	Certification:	4 Homicide	Dulla	ing, etc. (Specify)						City or Tow	n, State)		
	To the Hospitel or Al within 24 hours after of To the Funeral Dirac completely filled in by	edical	29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physician: To the Examiner: On the b	best of my knowl	ledge, death	occurred a	t the tim	ne, date and	d place, an	d due to the o	ause(s) ar	nd manner as s	itated. o the cause(s)
	To the within 24	Med	one) 29b. Signature and title of certifie	and man	stated.				number				signed (Month,	
)	F 2 5 8) //// (-	= B &		/				00				13 2000
•			30. Name and address of person	who completed cause	se of death (Item 2	23a) (Tvne	Print)		<u> </u>	00	93	Jan	wary	1 0000
514	5+1		William F. B	chaska	Annar.	95	wat	Pa	ul '	Stra	A. P	امم	phana	MD 217/3
	Sta		31. Date filed (Month, Day, Year	5 2006 32. F	Redistrar's Signatu	re	£ .1							
	Regist	rar	JAN	U ZUU0	Therew ,	J. 14	person							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 17:23 M 06 Laurence Howard Dennis /Medical 4a, Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Worcester Berlin If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 **X**M 2□ F Months 70 8/18/1935 MD Director 214-34-7282 Usual Residence of Decedent with the Maryland 10a, State 10c. City. Town or Location 10d. Inside City Limits 10b. County the Medical Exeminer road by notified at 1 Yes 2 □ No Director or 28a-f Worcester Berlin 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or Itams 23a USA 19 Gay St. 21811 death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □X/es 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bfack, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) Colfege (1-4or 5+) 8 Truck Driver Trucking other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Laurence C. Dennis Bernice Austin ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Florence Dennis 19 Gay St., Berlin, MD 21811 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ₹ 1

Burial 2 □ Cremation 3 □ Removal from State ö permit. Page Depertment of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Truitt Cemetery 1/6/2006 Powelville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart airure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ZNOXIL **Physician** en ceph2 /Medical Due to (or as a consequence of): Examiner Czrdice if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed CONCEST WE Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4 Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown مَ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 28 7 Vital 1 Yes 2 No 25. Was case referred to medical 26. Place of Death | Check only one examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient Medical Certification: To 2 ER/Outpatient 3 DOA ō 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division Hospital or Attending 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident investigation thours after death uneral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item Robert D-/K-) 9733

Registrar

State

31. Date filed (Month, Day, Year)

ORIGINAL

32. Begistrar's Signature

2006

			_ State	State of Maryland		artment of F			ienę 006	01190
			Registrar 1. Decedent's Name (First, Middle, Last)			timodio or	Dodin	2. Date of Death	h	3. Time of Death
	Physicia	an	STEVEN BERNARD DAT	CHER				JANUARY	01, 2006	7:40A M
	/Medic		4a. Facility Name (If not institution, give str			4b. City, Town, o	r Location of Death		4c. County of E	
	Examin	er				WALDORF			CHARLES	3
			5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9	Birthplace (State or Foreign
16	Funeral Director			^{1 2□F} 54	Yrs.	Months Days	Hours Min.	(Month, Day,	1951 WA	ASHINGTON, DC
		1	Usual Residence of Decedent					JOURT OF	, =	
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mar	ģ	MD CHARLES	WAI	LDORF					1 X Yes 2 ☐ No
	r 28s	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What	t Country?
	h wit	0 6	6311 JOSEPHINE ROA	D		20601		1	UNITED ST	TATES
	deat ma	Funeral	11. Marital Status	. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No-		American Indian, Vhite, etc.
9	atter or ite		1 Never Married X Married	1 ☐ Yes 27 No Il Yes, Give	1	1 ☐ Yes 2√E No	Specify:			
8	rei',	d b	3 Widowed 4 Divorced	Year or Dates:		X	ороспу.		Specify: I	3LACK
Ω.	72 h	Completed	15. Decedent's Educa (Specify only highest grade	ition completed)	(Give	dent's Usual Occup kind of work done	during most of wor	king	16b. Kind of Busine	ess/Industry
2	ithin 18.	du	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	d)		EDVIC	TTON.
7	ygier ygier t, th	Co		6		TEACHER	40 Markada Mar	- Cina Middle A	EDUCA	ATTON
Maryland 21215-0036	be filed within 72 hours after death with the Maryland all bygiene. All bygiene. All bygiene. Active than "naturel", or items 23e or 28e-f show event, the Madical Examiner must be notified at event, the Madical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, A		
<u>X</u> a	2 should be filed within 72 hours atter death with the Marylan and Mental Hygiene. Is marked other than "naturel", or itema 28s or 28s-f show aumatic event, the Medical Examiner must be notified at	၉	THOMAS MILTON DATCH		T			ELIZABETH I		
ā	s 1 end 2 should t Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type		1	•		iral Route Number,		
	ss 1 end 3 of Health Item 27 r other tr		SHARON DATCHER/WIFE				E KOAD, W	ALDORF, I	MAKYLAND 20c. Location - City	
9			20a. Method of Disposition 1 → Burial 2 → Cremation 3 → Re	moval from State	metery, crei	sition (Name of matory or other pla				
Ξ	Pages ment of I ant: if it ury or o		4 ☐Donation 5 ☐ Other (Specify)	MEIR	OPOLITA	N UNITIED ME	шн, сем о	1/06/2006	INDIAN H	EAD, MD
Baltimore,	permit. Page Department of Important: if eny injury or once.		21. Sandure of Furieral Pervice Downser	in your	TH	2. Name and Addre	SS OF FACILITY UNERAL HO	ME. P.A.		
<u> </u>	20 E 9 9			ON JOHNSON	34	<u>39 LIVIN</u>	GSTON ROA	D. INDIA		
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death cause on each line.	. Do not ent	ter the mode of dyi	ng, such as cardia	or respiratory arg	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Chronic	obot	ructive	Sulmons	in dista	ise	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	uence of):	0.00.00	1	0		
	Examiner		Sequentially list conditions b.	sarro	dosi	9 -				
	D =	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a .ons ∞ t	ience of):	101				
	cute	Examiner	that initiated events c.	Marke	0 /	recure	2			
o	death certiticate be executed e ettending physicien and nd for use as the burial-transit	Ä	resulting in death) Last	Due to (or as a consequ	ence of):					
8760,	ysic he bu	dlcal	d.							
9	ng ph	Ned	IF FEMALE:							
Вох	eath certitic ettending p	an/	23b. Was decedent pregnant	c. If yes, outcome of pregna 1 Live birth 2 Fetal		⊒Ectopic pregnand	y		23d. Date of Month	f delivery Day Year
	dea ed fo	sicl	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de 9☐Unknown	eath 5	Other (specify)			li di di	buy rour
P.O.	thet the de ed by the detached	Physiclan/Me	9 Unknown					1		
	S 50	by	Part II. Other significant conditions cont	nbuting to death but not resu	ulting in the u	inderlying cause gr	ven in Part I.			te to the cause of death?
ğ	w requires been sign should be	ed						1 🗆 Ye	es 2 2 No 3 [Probably 4 Unknown
Š	> 11 0	plet						24a. Was a autops		e autopsy findings available r to completion of cause of
of Vital Records,	0 - 2	Completed						perform	ned? deal	
ta	lcian: Th certiticete ector, peg	0	25. Was case referred to medical				26. Place of De	ath (Check only on	(e)	
>	d is	To B	examiner?	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA Ot	her: 4 Nursing I	lome 5 7 Reside	ence 6 Other (Specify)
0	g Ph ter th teral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	ol 28c. Inju	ry at	28d. Describe ho	ow injury occurred	
Ö	Attending r death. ector: After oy the fune	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	,,.,			Yes 2 □ No			
Division	ar de	======================================	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, st	reet, lactory, office		281. Location (St City or Town		or Rural Route Number,
Ö	s atte	Certification:								
	Hospital 14 hours Funeral tely filled	ca	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	cian: To the best of my kno	wiedge, deal	th occurred at the to	ime, date and plac	e, and due to the caurred at the time, d	ause(s) and manne ate and place, and	er as stated. I due to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	one)	and manner stated.						
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1141/		29c. Licen	se number	2	9d. Date signed (A	wonth, Day, Year)
				1111 on		1)2	25 14		1/5/0	6
			30. Name and address of person who cor	npleted cause of death (Item	23а) (Туре	, Print)	Cunts 0.0	סמ דאנז פר	DE MD 2	0604
W	1910		R. TIMOTHY PACE, N				, DIE. 20	02, WALDO	Kr, FID Z	
	Sta Regist	ate	31. Date filed (Month, Day, Year) JAN 0 3 2	32. Registrar's Signa	L.d	boule				

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(3)	<i>\$</i>		1 - State Registrar 1-12-06			cr	Cer	tificate of	Death	2. Date of E	Reg. N	io. U U		3. Time of Death
	Physicia	an	Decedent's Name (First, I Lawrence	Len.		aniels				Month	D	ay 2000	ear	
	/Medic	al			J			4h City Town	or Location of Death	Januar		2006 c. County of E	Joseph	4:03 P M
	Examin	er	4a. Facility Name (If not insti	_	e street and number)						1	rince		raata
6	Europal		7504 HAWTHORI 5. Social Security Number	NE 6. S	ex 7. Ag	e (In yrs. last b	irthday)	LANDOV. If Under 1 Year	If Under 24 Hrs.	8. Date of E				ace (State or Foreign
60	Funeral Director		578-50-2511 Usuat Residence of Decede		M 2□F	67	Yrs.	Months Days	Hours Min.	March March			Vast	nington, DO
	death with the Maryland ime 23a or 28e-1 ehow fin unt be positied at	or	10a. State 10b. Co		eorge's	10c. City, Tov		ation					10	0d. Inside City Limits 13 Yes 2 □ No
	28e-	Director	10e. Street and Number	ice G	eorge s	Landov	er_	10f. Zip Code			10g. C	itizen of Wha	t Count	try?
	3a or			C				2078	85			ted Sta		•
	ne 23	Funeral	7504 Hawthor	ne S	12. Was Decedent	Ever in U.S.	13. \	Vas Decedent of H	Hispanic Origin? (Spi an, Mexican, Puerto	ecify Yes or I	No-	14. Race - /	America	an Indian,
Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent; if Item 27 is marked other then "natural; or iteme 23a or 28e-1 ehovery injury or other treumatic event, the Madical Examiner must be natified at once.	þ	1 Never Married 2		Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No		Yes, specify Cub ☐ Yes ★★No		Rican, etc.)		Black, \ Specify:	White, 6	
2-0	72 ho	ted		edent's Ed	ducation de completed)	168	a. Deced	ent's Usual Occup	pation during most of work	ina	16b.	Kind of Busin	ess/Ind	lustry
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72	ygier ygier yer th	ပိ	10				Pa	inter	T			Unive	ersi	ty
Pu	be fill	Be	17. Father's Name (First, Mi						18. Mother's Name			ın Sumame)		
2	ould Mer Anrke	2	William Dani		T 0 :				Beulah E			T 0:	7 m	
Mar	12 sh h and 7 ie m treum	8 3	19a. Informant's Name/Rela						and Number or Run	al Route Num	iber, City	or Town, Sta	te, Zip	Code)
e,	1 end Health em 2 ther 1		Doretha Dani 20a, Method of Disposition	els l	King (Daug			Thunder		Colum Date		MD 21 Location - Cit		
آو	Ages in the		1 🔀 Burial 2 ☐ Crema			cemet	ery, cren	atory or other pla						
Baltimore,	it. Partmer rtmer rtent njury		4 ☐ Donation 5 ☐ Oth 21. Signature of Funerat Se		1 10	Fort	inco	ln Cemet	tery 1/14 ss of Facility For	/2006	Bre	ntwood	1, M	ID
Bal	Department Department Impo		21. Signature of Funeral Se		11 11 19	and from			ensburg Ro					
			23a, Part1. Enter the diseas	01,000	olications that cause	d the death Do	-					vood, r	עוב	Approximate
			shock, or heart failure.	List only	one cause on each l	ine.				or respiratory	a1103t,			Interval Between Onset and Death
	Pnysician /Medical		disease or conditi n	-	a			ovascular	Disease				1	
	Examiner				Due to (or as	a consequence	∍ of):							
		i i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying											
	cuted nd ransit	amlner	Cause (Disease or injury	~										
ć	Attending Physician: The law requires that the death certificate be executed rideath. rideath. ector: After this certificate has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transl.	Exa	that initiated events resulting in death) Last		Due to (or as	a consequence	of):							
260	icate be exe physicien ar s the burial-t			l	đ									
68	ncertificate be exe inding physicien ar use as the burial-t	ed			.									
ŏ	ettending for use a	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnar	nt	23c. If yes, outcome		. a -	C-Accid				23d. Date of	delive	гу
m.	that the death ed by the ette detached for	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No		4 ☐ Pregnant a	2 Fetal deat t time of death		Ectopic pregnanc Other (specify) _	У			Month	1	Day Year
o.	at the di by the stached	hys	9 Unknown		9□ Unknown									
Š,	es tha igned be de	by P	Part II. Other significant co			out not resulting	in the u	iderlying cause gr	ven in Part I.	23e. Dio	tobacco	use contribu	te to the	e cause of death?
Ď	v requires been sign should be	ed	Throat Cance	er, his	story					1	Yes	2 □ No 3 □] Proba	ably 4 Unknown
် မ	law re as be 2 sho	Completed								24a. We	is an	24b. Wer	e autop	osy findings available apletion of cause of
æ	The ste ha	E								, рег	formed?	deal	b ?	2 No
ita	lan: prtifice ctor.	Be	25. Was case referred to me examiner?	edical					26. Place of Deat					
>	nysic nis ce	To E	1 XYes 2 No		Hospital: 1 🗆 tnpati	ent 2 ER/C	utpatien	1 3□ DOA Ct	her: 4 🗆 Nursing Ho	me 5□Re	sidence	€€XOther (Specify	at scene
0	ng Pt fter tt neral	Ë	27. Manner of Death 1 Natural 5 □ P	ending	28a. Date of Inju (Month, Da	ury 28b.	Time of	28c. Inju Wo		28d. Describ				
<u>ō</u>	endir sath. or: Al	atic	2 Accident in	vestigation	n	100]Yes 2 □ No					
Division of Vital Records, P.O. Box 68760,	or Atter de lirecton Dy ti	Certification:	3 ☐ Suicide 6 ☐ C 4 ☐ Homicide d	ould not be etermined	289. Place of un	jury - At home, tc. (Specify)	farm, str	et, factory, office		28f. Location City or T	(Street a	and Number o	r Rural	Route Number,
	urs al				M									
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2X Me	dicat Exan	nysician: To the best niner: On the basis of and manner st	of examination a	ge, death and/or in	estigation, in my	opinion, death occurr	and due to the	e, dale a	nd place, and	due to	the cause(s)
	Tot Tot	Σ	29b. Signature and title of c	ertitier	^			29c. Licens				ate signed (A		
			1/ 1/ 1/07	ne	WW)			0.0	.M.E.		Jan	uary 5	, 20	006
00			30. Name and address of pe	erson who	completed cause of	death (Item 23a) (Type,	Print)	troot D-	1+iman	0 14	0.007.1 0.00		21201
1			Jutto	VL	were il	w		r term 2	treet, Ba	LLIMOE	e, 14	aryran	J. 4	~
	Sta Registr		31. Date filed (Month, Day, JAN 1 2			rar's Signature	has	20						

VID	B. DUI	FFY	- State of Maryland / Dec	artment of Health and M	lental Hygier	ne	
			101	ertificate of Death	Reg. I	2006 0110	2
	Physici	20	Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of De	ath
	/Medic		DAVID BRIAN DUFFY		JAN. 12		A^{M}
	Examin	er	4a. Facility Name (If not institution, give street and number) 283 BLAKE ROAD	4b. City, Town, or Location of Death ELKTON		4c. County of Death CECIL	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Birthplace (State of Fr	oreign
	Director		217-76-4947 15 M 2 F 48 Yrs.	Months Days Hours Min.	JUNE 22,	9. Birthplace (State or Formula) Country) NEW YORK	
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City L	imits
	Mary	to	MARYLAND CECIL ELKTON			1 Tes 2	∑ No
	th the	lrec	10e. Street and Number	10f. Zip Code		Citizen of What Country?	
	ath w	ral	283 BLAKE ROAD	21921		NITED STATES	
	Item Inern	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Never Married} \) 2 \(\text{Married} \) Married 13. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{Mar} \) No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - American Indian, Black, White, etc.	
21215-0036	within 72 hours after death with the Maryland ene. Then "ratural", or Iteme 23a or 28a-f ehow he Medical Examiner noted be molified at	र्व	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 No Specify:		Specify: WHITE	
5-0	72 hg	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired)	ng 16b.	Kind of Business/Industry	
121	within ene. then	Jup	Elementary/Secondary (0-12) College (1-4or 5+)	ACHINIST		CORE TECHNOLOGIES	3
	i Hygir other	Be Co	17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·	(First, Middle, Maid		,
/lar	should be tind Mental in marked or umatic eve	To B	ROBERT DUFFY	MARILO	U LAHRMER		
Maryland	12 sho			ing Address (Street and Number or Rura BLAKE ROAD, ELKTON			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiene. Importent: If them 27 is marked other then "natural", or Iteme 28a or 28a-1 show eny injury or other traumatic event, the Mardical Examinar must be notified at once.		20a Mathad of Disposition 20h Place of Disp	osition (Name of		Location - City or Town, State	
Baltimore,	Pages nent of int: if it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CHERT	JANUA TT CEMETERY 17, 2		ERRY HILL, MARYLA	AND
alti	permit. Depertm Importe eny inju			2. Name and Address of Facility ICKS HOME FOR FUNE			1112
	20 E 2 A		Donald & Plens	03 W. STOCKTON STR	EET, ELKTO	<u>ON, MARYLAND 2192</u>	.1
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final		r respiratory arrest,	Approximate Interval Betwee Onset and Dea	
	Physician /Medical		disease or condition resulting in death) a. Cardiac + aug. Due to (or as a consequence of):	ronade			
	Examiner		Andie wante	re			
N	o ii	iner	Sequentially list conditions, in any, leading to immediate cause. Enter Undertying Cause (Disease or injury				
V	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8760,	death certificate be executed e attending physicien and ad for use as the burial-transit		d				
9	ntification of physical physic	Medi	IF FEMALE:				
Вох	leath certifica attending ph I for use as th	lan/	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy		23d. Date of delivery Month Day Yea	r
P.O.	that the de led by the s detached t	Physician/Medical	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		,	
	law requires that the es been signed by th 2 should be detache	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of deat	h?
of Vital Records,	w requires that been signed t should be det				1 Yes	2 No 3 Probably 4 Qunki	nown
Sec	hesbe ge 2 sh	Completed			24a. Was an autopsy	24b. Were autopsy findings ava- prior to completion of cause	ılable e ol
a H	T age				performed? 1XYes 2□1		
₹	Physicien: this certifice ral director, I	To Be	25. Was case referred to medical sxaminer? Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death	n <i>(Check only one)</i> me 5 ☐ Residence	6XXX0ther (Specify) AT SCE	NE:
o c	ding Phys h. After this funeral di		27. Manner of Death 28a. Date of Injury 28b. Time		28d. Describe how in		1111
<u>S</u>	Attending r death. actor; After by the fune	catic	2 Accident Investigation	M 1 Yes 2 No			
Division	after of At	Certification;	4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide	treet, lactory, office	281. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)	
_	ospita hours uneral y filled		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, dea	th occurred at the time, date and place, a	and due to the cause	(s) and manner as stated.	
	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: Aller th completely filled in by the funeral	ledical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or in and manner stated.				
	or 100	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E		Date signed (Month, Day, Year) AN. 13, 2006	
			30. Name and address of person who completed cause of death (Item 23a) (Type			,	
	2			NN STREET, BALTIMO	RE,MARYLAN	ND 21201	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Registr	ar	JAN 2 0 2006	942			

			1 - For Stete Registrar	State of Ma	-	-	rtment d			nd Me	-	giene Reg. No.	000	5 01	193
	Obveisi		1. Decedent's Name (First, Middle, Last								2. Date of De Month	ath Day	Ye		of Death
	Physici /Medic		Henriett								January	y 9,	2006	4:45	АМ
	Examin	ner	4a. Facility Name (If not institution, give				4b. City, Tov			Death			County of D		
			Ruxton Health of D 5. Social Security Number 6. Se		e (In yrs. last birt	thday)	Den If Under 1 Y	ton	I If Under 2	4 Hrs.	8. Date of Bir		Carol	Ine Birthplace (State	as Fomian
	Funeral Director			M 2 F		Yrs.		ays	Hours	Min.	Sept. 2	ay, Year)		Country) Maryland	-
			Usual Residence of Decedent	A						1	Берс. 2	219 13	712	. rar yrano	
	larylan show	Ļ	10a. State 10b. County		10c. City, Town		ation							10d. Inside	•
	88-f	Director	Maryland Carolin	<u> </u>	Dent	ton									s 2 □ No
	a or 2	Dir	10e. Street and Number 323 Carter Avenue				10f. Zip Co	1629	a			_	en of What	country? ites of 1	A meric
	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or Items 23a or 28e-f show event, the Medical Exampler must be rodified at	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. W	1			in? (Spec	cify Yes or No			merican Indian,	- In CIIC
(0	ifter dea ir Items iir items	Fun	1 Never Married 2 Married	Armed Forces? 1 Tes 2 1		If	Yes, specify	Cuban,	, Mexican,	Puerto P	tican, etc.)		Black, W	hite, etc.	
93	ral', o	by	3 ☐ Widowed 4 ☐ Pivorced	If Yes, Give Year or Dates:		1	☐ Yes 2☐	XNo	Specify:				Specify: Ca	ucasian	
5-0	72 hc	Completed	15. Decedent's Edu (Specify only highest grad		16a.	Decede (Give k	ent's Usual O kind of work di O NOT use re	ccupati lone du	ion iring most o	of workin	g	16b. Kin	nd of Busine	iss/Industry	
121	within and the send of the sen	ldm	Elementary/Secondary (0-12)	College (1-4or 5	5+)							Ма		turing	
d 2	filed with Hygiene. other ther		11 HS Grad 17. Father's Name (First, Middle, Last)			Dut	ton Cu			's Name	(First, Middle	. Maiden S	Butt	ons	
Baltimore, Maryland 21215-0036	should be filed and Mental Hygi marked other matic event, I	To Be	Ascom	Wheatley							Eda A		24		
ary	W L 7	 	19a. Informant's Name/Relationship (Ty		19b.	Mailing	Address (St	treet an			Route Numb		Town, State	e, Zip Code)	
Σ	C = 01 L		T. Fleetwood Elben	Son					ghwa	y, D	enton,	Mary	land	21629	
ore	T = of		20a. Method of Disposition 1 □Burial 2 □ Cremation 3 □F	lemoval from State	20b. Place of cemeters	Dispos y, crem	ition (Name o atory or other	of r place)		Da	ite	20c. Loc	ation - City	or Town, State	
Ë	. Pages tment of tant: If It jury or o		` 4 ☐Donation 5 ☐ Other (Specify)	m	Green		ınt Ce					Hills	sboro,	Marylar	ıd
Bal	permit. Page Department Important: If any injury o		21. Signifure of Juneral Service nicens	il har	<u> </u>	²² M	Name and A oore F 12 Sout	ddress une th S	of Facility Pral H Second	lome d Sti	, P.A. ceet, D	entor	n. Mar	cyland 2	1629
П			23a. Part1. Enter the disease or compl shock, or heart failure. List only or	ications that caused ne cause on each fir	I the death. Do n ne.	not ente	r the mode of	f dying,	such as ca	ardiac or	respiratory a	rrest,		Approxim Interval B	etween
	Physician		Immediate Cause (Final disease or condition resulting in death)	Pne	Remore	19								Onset and	ays
	/Medical Examiner		resulting in dealin)	Due to (or as	a consequence of	of):									1
		- G	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of	of):									
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus. Underson in jury that initiated events												
oʻ	cate be executed obysician and the burial-transit		resulting in death) Last	Due to (or as	a consequence o	of):	-								
8760,	ate be nysicia he bu	dlcal		d											
9	ing ph	Med	IF FEMALE:		_										-
Box	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death		Ectopic pregn					23	3d. Date of Month	delivery Day	Year
<u>o</u> .	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Me	1 ☐ Yes 2 █ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5 🔲	Other (specify	y)						,	, 52,
Δ.	res that the igned by be detacted		Part II. Other significant conditions con	ntributing to death be	ut not resulting in	the und	derlying caus	e given	ı in Part I.		23e. Did t	obacco us	e contribute	e to the cause of	death?
Records,	uires n sign lid be	d by	Alzheemers	Demen	tig						10	Yes 2	∮ No 3□	Probably 4	Unknown
8	sw requir s been si 2 should	lete		•							24a. Was	an	24b. Were	autopsy finding	s available
Re	The law requires that ate has been signed b page 2 should be deta	Completed									autor perfo	osy rmed? 20 No	prior death	to completion of	cause of
Vital		0	25. Was case referred to medical					2	26. Place o	of Death	(Check only o		- '-	65 2 100	
of V	Q 5. 7	To B	examiner?	lospital: 1 🗌 Inpatie		tpatient	3□ DOA	Other:	4 Olurs	sing Hom	e 5 Resi	dence 6	□Other (S	pecify)	
ם	E je l	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry Year) 28b. T	ime of njury		Injury a Work?			3d. Describe I	how injury	occurred		
Sio	Attanding er death. rector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	On Discontinu	At home for				s 2 No		76 nantina //	C44	I Aloumba a a a	Com I Courte Ma	
Division	in Sir G	Certification;	4 Homicide determined	28e. Place of Inju- building, etc	c. (Specify)	iiii, strei	et, ractory, on	IIC O		20	City or To	wn, State)	Number or	Rural Route Nu	mber,
_	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical C	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best oner: On the basis of and manner sta	examination and	, death d/or inve	occurred at the	he time, my opir	, date and nion, death	place, ar	nd due to the d at the time,	cause(s) a date and p	and manner place, and c	as stated. Jue to the cause	(s)
	Fo the within Fo the comple	Me	29b. Signature and title of certifier	∞			29c. Lic					29d. Date	signed (Mo	onth, Day, Year)	
	. 220		1 Sleetiel	WL	mo		D	35	528	4		1/10	9/06		
			30. Name and address of person who co	impleted cause of de	eath (Item 23a) (Type, P	rint)								
			Andrea Allen, M.D		outh Was	hing	ton St	reet	t, Eas	ston,	Maryl	and	21601		
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 0 2	32. Registra	ar's Signature		rdi.				-		_		
	riegisti	uı		A Comment	The M.		MARA								

			1 - For State Registrar	State of Ma	aryland		artmen rtificat			nd Mer		giene Reg. No.	06	01194
	Physici //Medic	an	1. Decedent's Name (First, Middle, Last PAUL KIRBY	EYLER	,5R	•				2.	Date of De Month	Day	Year 200	3. Time of Death 6 23 35 M
	Examin	er	4a. Facility Name (If not institution, give CARROLL HOSPITA L	CENTER			WEST	MINS				CA	RROL	<u></u>
L	Funeral Director		5. Social Security Number 6. Se 213-38-7854 Usual Residence of Decedent	מא מחר	e (In yrs. la:	Yrs.	If Under Months	Days	Hours	Min.	Date of Bin (Month, Da 0 8 20	1931		thplace (State or Foreign buntry) aryland
	Maryland I-f show	tor	10a. State 10b. County Maryland Carrol	1	10c. City,	Town or Lo	cation	We	estmin	ster				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with the Marylan 23e or 28e-f show	Funeral Director	10e. Street and Number 2396 Cross Sectio	n Road			10f. Zip	Code	2115	8		10g. Citizer	of What Co USA	ountry?
9036	ours after de	þ	11. Marital Status 1 □ Never Married 2 및 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 XYes 2 ☐! If Yes, Give Year or Dates:		'	Was Deced If Yes, spec		panic Origin , Mexican, E Specify:	n? (Specify Puerto Rica	Yes or No an, etc.)		Race - Ame Black, White ecify:	orican Indian, e, etc. white
Maryland 21215-0036	within ene. than "	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12		5+)	life.	dent's Usua kind of wo DO NOT us DOGTA]	rk done di se_retired)	tion uring most o	f working			of Business/ ertisi	•
yland	2 should be tiled and Mental Hygin and Mental Hygin Is marked other raumatic event,	To Be (17. Father's Name (First, Middle, Last) Mervin Earl Eyle	er					Vio	la Jo	hnson			
, Mar	Ith ar 27 is r trau		19a. Informant's Name/Relationship (T) Marilyn Eyler, wif		OOL DIA	2396	Cros	s Sec	otion	Rd, V	Westmi	inster	, MD	21158
Baltimore,	00		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ I → 4 □ Donation 5 □ Other (Specify,	•	Mea	ce of Disponetary, crer dow B:	natory or o ranch	cem.	. 01	/06/2	2006	West	minste	Town, State er, MD
Bal	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licens	Duitro	01191	5 9	1 Wil	lis S		, Wes	stmins	ster,	Funei MD 21	
10	Physician /Medical Examiner	iner	23a. Part Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any leading to annual to a manager acause. Enter Underlying Cause, Disease or injury	a. NTRACR Due to (or as	NINL e conseque TUM	BL once of):	EEN	e or aying	, such as ca	traiac or re	spiratory ai	rrest,		Approximate Interval Between Onset and Death
68760,	death certiticate be executed e attending physician and ind for use as the burial-transit	edical Examin	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):								
О. Вох	it the death certitic by the attending p tached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal c	leath 3	Ectopic pr Other (sp					23d	. Date of del	ivery Day Year
rds, P	es tha igned be de	by	Part II. Other significant conditions co	ntributing to death b	ut not result	ting in the u	nderlying c	ause givei	n in Part I.		23e. Did to			the cause of death?
al Records,	The ate h page	Completed					<u>-</u>			_			prior to death?	itopsy findings available completion of cause of 2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other	26. Place of					
ō	ing Atter une	atlon; To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ıry 2	R/Outpatier 28b. Time of Injury		Bc. Injury Work	4 Nursi	28d		dence 6 L	Other (Spec	cify)
Division	spital or Attend ours atter death herel Director: tilled in by the f	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At hom c. (Specify)	ne, farm, str	eet, factory	r, office		28f.	Location (S City or Tov		umber or Ru	iral Route Number,
	Hos Fur Fur	edical		sician: To the best iner: On the basis o and manner st	f examination									
)	W	29b. Signature and title of certifier					i. License	number 8 580			29d. Date s	<i>r</i>	h, Day, Year)
	MULS	eser e	30. Name and address of person who can be a series of person who c	ompleted cause of c	leath (Item 2				DWIE		20	715		
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signatu		hank							

			1- For State of Maryland / Dep	artment of Health and Mertificate of Death	Mental Hygie	ZUHh	01195
			Decedent's Name (First, Middle, Last)	Timodio or bodin	2. Date of Death	-	3. Time of Death
	Physici /Medic		Sallie Mary Elliott		Jawurry	Day Year 2006	04:06 M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. Cily, Town, or Location of Death		4c. County of Death	
		ļ.	S. Social Security Number 6. Sex 7. Age (in yrs. last birthday) If Under 1 Year It Under 24 Hrs.	R Data of Bigh	Micon	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 4 - 34 - 5731 7. Age (In yrs. last birthday 7. Age (In yrs. l	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 11/8/193	9. Birth Cou	place (State or Foreign Intry) DE
			Usual Residence of Decedent		11,07.33		
	ehow	-	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	28a-f	Director	MD Worcester Berlin 10e. Street and Number	10f, Zip Code	100	0:4:	1 ☐ Yes 2 No
	with se or		9017 Stephen Decatur Hwy.	21811	Tog.	Citizen of What Cou	nuyr
	4 within 72 hours after death with the Maryland Jiene. r then "natural", or Items 23e or 28e-f ehow Ite Medicel Exambrat must be motified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp.	ecify Yes or No-	14. Race - Amer	
٥	after or its	Fui	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Hican, etc.)	Black, White	, etc.
000	hours a	d by	3 X Widowed 4 □ Divorced Year or Dates:				nite
7	n 72 n "nat	olete	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ung 16b	. Kind of Business/Ir	idustry
7 7	d within piene. r then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	sistant Manager		Restaurar	nt :
9	othe	Bec	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		
Z	Menta Menta arked	70 1	Vaughn Tilghman	Rachel	Thomason	า	
Jar	2 short and reum		1	ing Address (Street and Number or Run			
e e	s t and f Health item 27 other t		Cindy Shoemaker 9017 20a. Method of Disposition 20b. Place of Disp	Stephen Decatur		erlin, MD Location - City or T	
DE I	ages int of t: if it		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery, cre	ematory or other place)	200		
Ξ	nat. Postante ortani injury			nlopen Crem. 1/9 22. Name and Address of Facility Th		Frankfor	d, DE Home
io D	Departing Departing Important In portant Important In portant In p			108 William St., Be			Tionic
ň	The state of	200	2. Part. Enter the lisease, or complications that caused he do the pronot or shock, or heart lilure. List on the cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,		Approximate tnterval Between
	Physician	, ,	Immediate Cause (Final disease or condition	iono atlas			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):		21.		Marin 2
	LXdillilei		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	onay Jean	1888		1960
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	Silverto Sedo	· L.		Seus
	be executed icien and burial-transit	Examin	resulting in death) Last c Due to (or as a consequence of):	1 acc	U S		
0/0	cate be executed physicien and the burial-transit	dicai	d				
Ď	ntifica ing ph	Med	IF FEMALE:				
X Q	the death certificate y the attending physiched for use as the	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnancy		23d. Date of deliv	rery Day Year
5	he de	ysic	1 Yes 2 Wo 9 Unknown Unknown 1 Yes 2 Wo 9 Unknown 1 Yes 2	Other (specify)			
ř.	uires that the de signed by the a ld be detached f		Part tt. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to t	the cause of death?
cords	requires that been signed b hould be deta	ed by	End- Inge le	ind Jacker	1 ☐ Yes	2 No 3 Pro	bably 4 Jinknown
ဝ	sicien: The law requir certificete has been si rector, pege 2 should	Completed	Deviplus vasulare	mitte	24a. Was an	24b. Were auto	opsy findings available
r	The law ete has b pege 2 si	E O	Sepsis	Dialets	autopsy performed 1 ☐ Yes 2 ☑	2 death?	ompletion of cause of
Z	cian: ertifica	Bec	25. Was case referred to medical examiner?	26. Place of Deat	h (Check only one)		
5	Physician: rthis certific ral director,	၉	1 Yes 2 ER/Outpatient 2 ER/Outpatient		ome 5 Residence		<i>fy</i>)
	ding I h. After funer	llon	27. Mapper of Death 1 Hatura 5 Pending (Month, Day Year) Injury 2 N Accident investigation	of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	njury occurred	
UNISION	deati ctor: y the	fical	3 Suicide 6 Could not be 28e. Place of triury : At home, farm, si		28f. Location (Street	t and Number or Run	al Route Number.
S	el or sefte	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, Si	tate)	
	To the Hospitel or Attending Physicien: within 24 hours eller death. To the Funerel Director Affer this certific completely filled in by the funeral director.	ledical (29a. Certifier (Check only (Ch	th occurred at the time, date and place,	and due to the cause	e(s) and manner as s	stated.
	the H hin 24 the F nplete	Medi	and manner stated.				
	to to cor	-	29b. Signature and title of certifier	29c. License number	290.	Date signed (Month,	Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (Type	D16725		0 3 (0	-
. +	1,2		TAP CONSTANTS 13 40 5.00	Jisin St. sul	bshull	MO -	71814
J	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		·	-	
84 63	Registr	-	JAN 0 6 2006 Jun &	parti			
()HI	MH 17 Pay 1/2	nn1	-				

		For Stata Registrar			artment of Health an rtificate of Death		giene () () ()	01196
Physicia /Medic		1. Decedent's Name (First, Middle Bettie	, Last) Mae	Eisendr	ath	Jane of De Jane 1	, 20 ^y 06 Yea	3. Time of Death 1110 M
Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or Location of D	eath	4c. County of De	ath
		Montgomery (Olney		Montgo	
Funeral Director		5. Social Security Number 474-24-6152 Usual Residence of Decedent	6. Sex 7. Age	(In yrs. last birthday) 84 Yrs.	Months Days Hours M	Min. 8. Date of Bird (Month, Da 8 / 19 /	y, Year) 1921 M	inthplace (State or Foreign Country) innesota
ith the Maryland or 28a-1 show	tor	10a. State 10b. County	gomery	10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes ※ No
h with the 23a or 28a at be noti	al Direc	10e. Street and Number 8 Manorvale	Court		10f. Zip Code 20853		10g. Citizen of What USA	Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examination must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 [Yes 2 [XNo If Yes, Give Year or Dates:)	Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, P	? (Specify Yes or No uerto Rican, etc.)		nerican Indian, hite, etc. White
vithin 72 hc ne. hen "natui e Medicel	Completed	15. Decedent (Specity only highes Elementary/Secondary (0-12)	s Education t grade completed) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of DO NOT use retired) Iomemaker	working	16b. Kind of Busines	,
Hygie Hygie ther t	ပိ	17. Father's Name (First, Middle, I	1			Name (First, Middle,		me
2 should be and Mental is marked or sumatic sve	To Be	Seward Alle	n Aldrich		Eva	Mae Wel	ch	1779
and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationsh Susan Eisen		ter 8 N	ng Address (Street and Number o Manorvale Cou	rt Rockv		
Pages 1 ment of He ant: if iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		20b. Place of Dispo cemetery, cres Chesape	position (Name of matory or other place) eake Crem. 1/	04/06	Beltsvil	
permit. Departr Importu		21. Signature of Funeral Service	le de	22	PHILIP D.RINA 2241 Columbia	LDI FUNE	RAL SERV	ICE, P.A.
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused to	he death. Do not en	er the mode of dying, such as car	diac or respiratory a	rrest,	Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. RES	PIRATO consequence of):	DRY PAIL	URE		Onset and Death
Examiner	10	Sequentially list conditions,	BIL.	ATERA consequence of):	2 PAEVME	NIA		DAYS
eath certificate be executed attending physician and for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	consequence of):				
rtificate bing physic	Medical	IE EENALE.	d.					
the d y the	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12.mopths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of o Month	delivery Day Year
iw requires that s been signed b should be deta		Part II. Other significant condition	ns contributing to death but	not resulting in the u	nderlying cause given in Part I.			to the cause of death?
	Completed					24a. Was autor perfo	osy prior t death	autopsy findings available o completion of cause of ?
ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Death (Check only o	one)	
Phys this ral dir	. To	1 Yes 2 No	Inpatien				dence 6 Other (S)	pecify)
ding h. After fune	tlon	1 Natural 5 Pending		Year) Injury	f 28c. Injury at Work? M 1 Yes 2 No	20d. Describe	how injury occurred	
or Attending Physician: after death. Director: After this certific. In by the funeral director,	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide	not be 200 Place of Injur	ry - At home, farm, str (Specify)		28f. Location (S City or Tos	Street and Number or vn, State)	Rural Route Number,
To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	edical C	29a. Certifier 1 Certifyin (Check only one) 1 Medical I	g Physicien: To the best of Examiner: On the basis of and manner state	examination and/or in	h occurred at the time, date and p vestigation, in my opinion, death of	lace, and due to the occurred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier	777		29c. License number		29d. Date signed (Mo	onth, Day, Year)
1		20 Name and address to	X // V	WS COLOR	D38457	7	ANUTH ?	2,2006
		30. Name and address of person of the control of th	D, '5801 IN	HERMOT	Drun Da, SIC	VER SI	MOUNTY:	UD 2000
Sta Registr		JAN 04	2006	, & Ap	arti			-0100

			For	State of Marylan				•	•	01107
			1 - State Registrar		Cei	rtificate o	f Death		Reg. No.	01137
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month		3. Time of Death
	/Media	cal	Robert Leslie FRYE 4a. Facility Name (If not institution, give s			4b Cib. Tour	, or Location of D	Janua	4c. County of E	26 17.25 W
	Examir	ier	Washington County			. 1	ersto			shington
ę	Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Day	ar If Under 24 I			Birthplace (State or Foreign Country)
	Director		214-09-3030	M 2□F 89	Yrs.	Worldis	3 (10013 11	Jan.	17,1916 V	irginia
	land w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Mary Fig.	tor	Maryland Washi	ngton H	lagerst	own				1 XYes 2 □ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23a or 28e-f ehow any injury or other traumatic event, the Medical Examinar must be notified at ance.	i Director	10e. Street and Number 1040 Benjamin Pl	ace	-	10f. Zip Code 217			10g. Citizen of What	t Country?
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent o	f Hispanic Origin?	(Specify Yes or No Jerto Rican, etc.)	14. Race - A	American Indian, Vhite, etc.
36	or Ite		1 Never Married 2 Married	1 ☐ Yes 2 🔀 No If Yes, Give		1 ☐ Yes 2X N		Jerio Moan, etc.)	Specify:	white
21215-0036	hour:	q pa	3 Widowed 4 Divorced	Year or Dates:	16a Dece	dent's Heuri Occ	upation		16b. Kind of Busine	
215	in 72	piet	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work dor DO NOT use reti	upation ne during most of red)	working	Tob. Kind of Busine	as symoustry
2	filed with Hygiene other the	Completed by	8	0	mana	ger			Army Corp	. of Engineers
nd	be file ital Hy id oth	Be	17. Father's Name (First, Middle, Last)						, Maiden Surname)	
Maryland	should be and Mental marked o umatic eve	P	Robert Frye 19a. Informant's Name/Relationship (Type	no Print	10h Mailie	a Addrona /Ctro		e Hickman		7-0-4-)
	and 2 sealth an n 27 ls i		Gertrude Frye - w	,					er, City or Town, Star town, Mar	yland 21742
ē,	es 1 al of Hea of Hea of Item r othe		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other p	1	Date	20c. Location - City	
altimore,	Pages nent of ent: If its ury or o		12 Burial 2 ☐ Cremation 3 ☐ Real Donation 5 ☐ Other (Specify)	emoval from State		11e Uni	- 1	1/14/06	Lovettsv:	ille, Va.
Balt	Departi Departi Importi eny inj		21. Signature of Funeral Service License	** T		2. Name and Add			NICH FUNE	
	00F 4 0		23a. Part1. Enter the disease, or complic	/anne					rstown, Mo	
- 3	* .		shock, or heart failure. List only on Immediate Cause (Final	ne cause on each line.	3		ying, such as car	diac or respiratory a	rrest,	Approximate Interval Between Onset and Death
5	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence		JOCK				
7.	Examiner		Commentation that the annual fairness in the latest annual fairnes			الران الا	th Rec	sin hor	· fortu	
	ם ב	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	uence of):	0 1	^	1	failu	
	be executed iicien and burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequ	reno	& for	Rure			
760,	be executed sicien and burial-transit	cal E		lactic		one				
68/	A > 0		- 0	<u>ache</u>	auc					
ROX	death certificat e attending phy d for use as th	Physician/Med	23b. was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnar	NCV.		23d. Date of	delivery
O.	0 0	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of de		Other (specify)			Month	Day Year
٦.	that the		Part II. Other significant conditions con		ulting in the ur	aderiving cause o	men in Part I	23e Did t	ohacco use contribut	e to the cause of death?
Hecords,	w requires that been signed b should be deta	d by	Closthoidium di					<i>y</i> 1□		Probably 4 Unknown
Ö	w req	iete	discourse opin	aharal d	12 8 01	00.	dilea	24a. Was	an 24h Were	autopsy findings available
_	ician: The law requires that the certilicate has been signed by th rector, page 2 should be detache	Completed	verses y	J/4.000 CO			un gan	autoj	osy prior death	to completion of cause of
Vital	Physician: this certific ral director.	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 10 No	lospital:	ER/Outpatien	t 3 DOA	ther	Death Check only o		
	ig Phy ter this neral c	\vdash	27. Manner of Beath	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. In			dence 6 Other (S	респу)
S S	Attending r death. ctor: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Bay Your)			Yes 2 No			
Division	el or Atten after deat Director: d in by the	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	eet, factory, office	9	28f. Location (. City or To		Rural Route Number,
	To the Hospitel or within 24 hours after To the Funeral Director completely filled in b	edical C	29a. Certifier 1 Certifying Phys	sicien: To the best of my knowner: On the basis of examinational and manner stated.	wledge, death tion and/or inv	occurred at the restigation, in my	time, date and pla opinion, death of	ace, and due to the courred at the time,	cause(s) and manner date and place, and c	as stated. due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				nse number		29d. Date signed (Mo	onth, Day, Year)
			masaous	a , 100		DE	2588		11101	06
, ,	_	1	30. Name and address of person who con	a ori -	1 A	Print)		- L H-	2 02 ×2 L2 0	normo 2/74p
) / /	-7 Sta	te	31. Date filed (Month, Pay, Year)	1 25 E C	- 1	nner	I'M SIY	C CY, 17C	3100	1, 40
	Registr	-0.	JAN 11 200		4. 1.	0.16.1				

	- State Registrar Certificate of Death		eg. No. CUI	Jb U119
cian	1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month One	Day Y	3. Time of Death
lical	Elizabeth Belle Grund 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1	1 200 4c. County of	
iner				
1	SALISBURY REHAB & NURSING CENTER SALISBURY MD 218 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 11 Under 1 Year 11 Under 24 Hrs. Months Days Hours Min.		Ygar)	Birthplace (State or Foreign Country)
r	218-09-7410 Yrs. 85	11/8/19	20 ′	MD
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
tor	MD Worcester Berlin			1 ☐ Yes 2X No
Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of Wha	at Country?
ral	6 Crest Haven Dr. 21811	and Van as No	USA	Amencan Indian,
Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 🔀 Married 1 □ Yes 2 □ No	Rican, etc.)		White, etc.
by	If Yes, Give 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced Year or Dates:		Specify:	White
Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Busin	ness/Industry
mp	Elementary/Secondary (0-12) College (1-4or 5+)		Dotail	Cales
CO		ne (First, Middle, M	Retail Maiden Sumame)	Sales
To Be			Hoffack	er
-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru			
	Charles Kenneth Grund 6 Crest Haven Dr., B	The second secon		
	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - Cit	
	4 Donation 5 Other (Specify) Lorraine Park Cemetery 1/6		Woodlawn	
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility T			al Home
	3a. Part I. Enterthe disease, or complications that tasked the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate
	Immediate Cause (Final	4		Interval Between Onset and Death
1	disease or condition resulting in death) Due to (or as a consequence of):	7		may
	Sequentially list conditions Sequentially list conditions			gear.
liner	Sequentially list conditions, if any, leading to immediate cause. Einer Underlying Cause (Disease) of Hijkey that initiated events c	<u> </u>	/	
Examiner	that initiated events resulting in death) Last Due to (or as a consequence of):			20017
calE	d.		190	
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of	ot delivery Day Year
/sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 5 ☐ Other (specify)		1007147	Day . oa.
Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tot	bacco use contribu	ute to the cause of death?
d by		1 □ Y€	es 2 10 3	Probably 4 Unknown
Completed		24a. Was a	n 24b. We	re autopsy findings available in to completion of cause of
E O		autops perform	ned? dea	r to completion of cause of th? Yes 2□ No
BeC	25. Was case referred to medical examiner?	th (Check only on		
2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 A Mursing H		ence 6 Other	(Specify)
Certification:	27. Manner of Death 1 Production 28a. Date of Injury 28b. Time of 28c. Injury at 2	28d. Describe ho	ow injury occurred	
Icat	3 Suicide 6 Could not be	28f. Location (St	treet and Number	or Rural Route Number,
ertil	4 Homicide determined building, etc. (Specify)	City or Town	n, State)	
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place			
edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.			7, 7
4	29b. Signature and title of certifier 29c. License number	8 2	9d. Date signed (I	Month, Day, Year)
Me			1 150 1	
Me	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		15/08	

		•	State of Maryland / Depar	rtment of Health and M ificate of Death		iene og. No.	01200
	19	150	Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
44	Physicia /Medic		Ralph Irvin GIBNEY Jr.		January		12:10 p.m.
	Examin			4b. City, Town, or Location of Death		4c. County of	Death
7.85			Homewood Retirement Center	Williamsport If Under 1 Year If Under 24 Hrs.		Washin	2ton
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	Date of Birth (Month, Day,	Year) 9	Birthplace (State or Foreign Country)
	Director		220-05-2308		May 16	1918 M	laryland
	and	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ation			10d. Inside City Limits
	Aaryli f sho	ō	Manada I II-lanahan				1 X Yes 2 ☐ No
	the 1	Director	Maryland Washington Hagerst	10f. Zip Code	10	Og. Citizen of Wha	at Country?
	with Be or	٥		21740		II C	
	leath	Funerai	10.90 Virginia Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. W.	21740 as Decedent of Hispanic Origin? (Spe	ecify Yes or No-		American Indian,
10	riter	Fun	Armed Forces? If	Yes, specify Cuban, Mexican, Puerto	Rican, etc.)		White, etc.
936	urs a	by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates: 1944-46	☐ Yes 2X No Specify:		Specify:	White
21215-0036	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show edical Examinar must be notified at	Completed	15, Decedent's Education 16a. Decede (Specify only highest grade completed) (Give k	ent's Usual Occupation and of work done during most of worki	na	16b. Kind of Busin	
21	within 7 ene. then "r	ple	Elementary/Secondary (0-12) College (1-4or 5+)	O NOT use retired)	9		
21	filed within Hygiene. other then	Son		cial Artist		Utility	company
nd		Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, N	Maiden Sumame)	
yla	should be and Mental marked o	ပ္	Ralph I Gibney Sr.	Margaret			
Maryland	and and is m	8 3	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rura	al Route Number,	City or Town, Sta	ate, Zip Code)
	s 1 and 3 if Health item 27 other tri		Barbara Bachtell -Step Daughter 101				
Baltimore,	ges 1 t of H if ites or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, cremit	atory or other place)	Date	20c. Location - Cit	y or lown, State
Ē	permit. Pages Department of I Important: If its eny injury or of	١.,	4 □Donation 5 □ Other (Specify) Rose Hi	11Cemetery 1/4/	06 H	lagerstov	m, Maryland
at	permit. Pag Department Important: eny injury once.			Name and Address of Facility Mi			
ш	205 3	0		5 E. Wilson Blvd.			
**			23a. Part1. Enter the disease, or complications that cause the death. Do not enter shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac of	or respiratory arre	est,	Approximate Interval Between
	Physician	8 8	Immediate Cause (Final disease or condition	10			254
7	/Medical		resulting in death) Duy to (or as a consequence of):		<i></i>	(
180	Examiner		Sequentially list conditions. b. WABIC 179	Offmore Ju	ene Ti	ions	
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	* (1/11/20
	ecute ind trans	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	MURC			4 menory
90	cate be executed physician and the burial-transit	<u> </u>	resulting in death) Last Due to (or as a consequence of):				
8760,	ate b	dical	d				
9		₩.	IF FEMALE:				
Box	ath c	Physician/Me		Ectopic pregnancy		23d. Date of Month	
<u>o</u> .	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)			
9.	that the de ned by the a detached f		Part II. Other significant conditions contributing to death but not resulting in the un-	deriving cause given in Part I	23e. Did tob	pacco use contribu	ute to the cause of death?
JS,	8 5 g	δ	HURCHTENSION	adilying daddo givon in rawin	1 □ Ye	V	☐ Probably 4 ☐Unknown
Records,	w requir been si should	Completed	1 -11-6701 00031				
ec	elaw hast je 2 s	ď			24a. Was ar autops perforn	y pric	re autopsy findings available or to completion of cause of lith?
E		S	the latest and the la		1 ☐ Yes 2	No 1	Yes 2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Deatl	elli-		
of	Physic this d	٩	1 tes 20 No 1 inpatient 2 Envoutpatient	3 DOA 4/2 Nursing Ho		ence 6 Other ow injury occurred	(Specify)
	ding f	lo iii	1 Natural 5 ☐ Pending (Month, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	260. Describe no	ow injury occurred	
Sic	Attending ir death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre		28f Location (St	reet and Number	or Rural Route Number,
Division	or At after of Direction by	Certification:	4 Homicide determined building, etc. (Specify)	et, factory, office	City or Town		or marar moute reamber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	CE	29a. Certifier 1 ** Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place	and due to the or	allee/el and mann	er as stated
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 adject Examiner: On the basis of examination and/or inviously one)				
	o the o the omple	Me	29b. Signal Annual Certifier	29c. License number	25	9d. Date signed (Month, Day, Year)
	⊢ 3 ⊢ ŏ		MARIAN MAXICIA MINISPER	1706		16011	7000
		1	30. Imme and address 4 except who completed cause of death (Item 23a) (Type, F	Print)	1	ALLO !	COVE
14	1-11+1		TETHEN CHANGE AND THE	5 Da THan 1	tre :	HARCES	TOUN,
	Sta	ate	31. Date filed (Month, Day, Year) 32. Resistrar's Signature	10,010	1	11/	. /
	Regist		JAN U 4 2006 Janesen S. S.	rele		1110	20192

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Grimes Mary January 1, 2006 1:45A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glade Valley Nursing & Rehab. Walkersville Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Oct.21,1909 Birthplace (State or Foreign
Country) **Funeral** 1 M 2 F Months Days Hours 96 217-28-6921 Yrs. Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10a State 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at Maryland Frederick Walkersville Yes 2 No Director 10f. Zip Code 21793 10g. Citizen of What Country? 10e. Street and Number 5 18 Frederick Street or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural; or Item any njury or other traumatic event, the Madical Exercitors page. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White δ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Manufacturing Bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Burrier Mae Ramsburg ဥ Grayson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11055 Haughs Church Rd., Keymar, MD 21757 Patty Green/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 01/04/06 4 ☐ Donation 5 ☐ Other (Specify) Glade Cemetery Walkersville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home, PA 40 Fulton Avenue, Walkersville, MD 21793 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each life. Ck, or heart Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) may /Medical Due to (or as-Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) sate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospitel or Attending Physicien: 24 hours efter death. Funerel Director: Atter this certifica funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 [] Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Magner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide To the Hospitel within 24 hours e To the Funerel C 29a. Certifier 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) (98 150 N 1475 31. Date filed (Month, Day, Year) 32. Registra's Signature State 2006 Registrar

		1 - For State Registrar MEND#19aperFH	State of Ma 1/4/06,BMW,M				nt of H te of L				giene Reg. No.		0	1202
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Exami		4a. Facility Name (If not institution, give Shady Grove Ad 5. Social Security Number 6. Se	ventist	/In I			r, Town, or Ro	Location of Ckv.	ille		N	County of Do	omer	
Funeral Director			x 7. Age □M 2ਊcF	84	ast birthday) Yrs.	Months		Hours	Min.	8. Date of Bird (Month, Da 3/18/	1 9 2	1 0	Country)	
e Maryland 3e-f ehow	ctor	MD 10b. County Montgom	ery		,Town or Lo		ring							Inside City Limits 1 ☐ Yes 2 🛣 No
th with th	Funeral Director	14632 Peach Orc	hard Ro	ad			ip Code 2090:	5				izen of What Germa		7
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilth and Mental Hygiene. Department of Heatilth and Mental Hygiene. Department of Heatilth and Mental Hygiene. Department of Heatilth and Mental Hygiene. Department of the fired of the Hygiene. Department of the Hygiene. Department of the Hygiene.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:				edent of Hi ecify Cuba X No	spanic Ori n, Mexican Specify:	gin? (Spe n, Puerto F	cify Yes or No Rican, etc.)		14. Race - Al Black, W Specify:	hite, etc.	
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should be file nd Mental Hy marked othe	To Be C	17. Father's Name (First, Middle, Last) Hans Hoppensac	k							(First, Middle, a Str		Sumame)		
and 2 sho saith and 1 n 27 is me er traume		19a. Informant's Miceath Susan MeCall/D					ss (Street a lame)			ve C				^{de)} 1d21029
permit. Pages 1 and 3 Department of Health Important: If Item 27 i eny injury or other tra		20a. Method of Disposition 1 □ Burial 2 🔯 Cremation 3 □ 5 4 □ Donation 5 □ Other (Specify		20b. PI	lace of Dispo pmetery, cren hesap	sition (Natory or eak	ame of other place Cre	em.	1/04	/06		cation - City ltsvi		
permit. Depart Import eny inj		21. Signature of Faneral Service Licens	ak,		9	241	Coli	umbi	a Bl		Tvei	SERV:	ICE,	P.A. Md2091
Physician /Medical Examiner Physician and	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of mmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line	consequ	uence of):					NFA		1011	Int Or	proximate erval Between isset and Death
To the Hospitel or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. tf yes, outcome of 1 ☐ Live birth 24 ☐ Pregnant at 19 ☐ Unknown	2 ☐ Fetaf	death 3		pregnancy specify)				-	23d. Date of o	delivery Da	y Year
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the Hospl in 24 hou the Funer pletely fill	edical	(Check only 2 Medical Exem	rsician: To the best of iner: On the basis of and manner state	examinat	wiedge, death tion and/or in	occurre vestigation	d at the time on, in my op	ne, date an pinion, dea	nd place, a th occurre	and due to the ed at the time,	cause(s) date and	and manner I place, and c	as stated	d. e cause(s)
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		30. Name and address of person who c	m. 7	Sila	0046.	Lovi	- 1			- 10				
St Regist	ate	31. Date filed (Month, Day, Year)	32 Registra	r's Signa	of Ap	ark	,							

Amended Item 16a per F.D. 01/04/2006 Carroll County, wjl
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	ite of Maryland /		ent of Heal ate of Dea			ene U U D	01203
	Physici		1. Decedent's Name (First, Middle, Last) Helen Elizabeth	Grinder				2. Date of Death January	3 ^{Pay} 2006 ^{Yeer}	3. Time of Death 1:20 a M
	/Medic Examin		4a. Facility Name (If not institution, give street a			City, Town, or Local		7	4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs. last I		nder 1 Year If U	Jnder 24 Hrs. ours Min.	8. Date of Birth May 28,		thplace (State or Foreign ountry) nsylvania
	yland low		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location					10d. Inside City Limits
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	th with t 23e or 2 ust be n	rai Dir	4239 Old Hanover Road	d	101.	Zip Code	21158	10	og. Citizen of What Co USA	ountry?
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212	filed with Hygiene ther thai		8	llege (1-4or 5+)	-Sew eamstres				Cloth	ıng
lanc	d la b	To Be	17. Father's Name (First, Middle, Last) William Howard Bl	essing		16.1		e (First, Middle, M e Marie S	Schuchart	
Maryland 21215-0036	12 should h and Men 7 Is marke treumatic		19a. Informant's Name/Relationship (Type, Pri MaRea Stonesifer, d		-				City or Town, State,	
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Ba	permit. Departr Importe any inj		Husto R. D	- when	> 91	Willis S	St, Wes	tminster	, MD 2115	
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I Records,		Completed						24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of 2 No
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Division	iel or Attendi s after death. el Director; A ed in by the fu	Certific	3 Suicide 6 Could not be determined 286	. Place of Injury - At home, building, etc. (Specify)	farm, street, fac	ctory, office		28f. Location (Str. City or Town,	eet and Number or Ri State)	ural Route Number,
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	1154		30. Name and address of person who complete	ad cause of death (Item 22)	a) (Tyne Print)	DO0 5	755	2	'///	2006
	*3		GOURISHAMAR	C-MAGAN	VMA	TOOA PO	004ER	D wear	tmin STER.	MD 21157
Fax:	Sta Registr		31. Date filed (Month, Day, Year) 1 Δ N 0 4 2006	32. Registrar's Signature	4 ha	1. 1				

			1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryland		ırtmen <i>tificat</i>					eg. No. UUb	0 2 0 l ₃
	Physici /Medio Examir	cal		o Chapa Garza		4b. City,	Town, or	Location of		Month Sawwa	Day Year	6 18:49 M
	Funeral Director		451-36-9/98	7. Age (In yrs. last	birthday) Yrs.	E11 If Under Months	ton 1 Year Days	If Under 24 Hours	Min.	Date of Birth (Month, Day, April 22	Ceci1 (Year) 9. Bi (1927 Te	rthplace (State or Foreign Jountry) XAS
	e Maryland Ba-1 chow	octor	Usual Residence of Decedent 10a. State 10b. County Maryland Cecil	10c. City, T	own or Lo							10d. Inside City Limits 1 XYes 2 No
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. At Hygiene. A chart tan "natural", or iteme 23e or 28e-f ehow orent, the Marical Exercines must be profiled at event, the Marical Exercines.	Completed by Funeral Directo	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu (Specify only highest grade		6a. Deced	Vas Deced Yes, spec	1921 dent of His city Cubar 2 \(\text{\text{No}} \) al Occupa	Specify:	Mexic	y Yes or No- can, etc.)	SORCITY	States encan Indian, ile, etc. exican— merican
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baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If Item 27 is marked ery injury or other traumatic a <u>pnce</u> .		20a. Method of Disposition 1 № Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Gard	ord l ens	Name an	ther place	1 of English	anuar	006	Aberdeen, A. Mary	Maryland
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DIVISION OF V	ding Phys h. After this funeral dii	ation: To B	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 ER/ 28a. Date of Injury (Month, Day Year) 28	Outpatien b. Time of Injury		8c. Injury Work	4 14012			nce 6 Other (Spewinjury occurred	ecify)
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	To the Hospital or within 24 hours afte To the Funeral Dirt completely filled in I	Medical	(Check only 2 Medical Examinone) 29b. Signature and title of certifier What Tarker	ner: On the basis of examination and manner stated.	and/or inv	estigation,	in my opi	number	occurred	at the time, da	ate and place, and du ad. Date signed (Mon	s stated. e to the cause(s) th, Day, Year)
	Sta Registr		30. Name and address of person who con H Fay L 65 31. Date filed (Month, Day, Year)	mpleted cause of death (Item 23	a) (Type, I	Print)	E	lkton	, ~	1,7		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2:30pm Physician 2006 Gale Jan. Elizabeth Catherine /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot St.Michaels 106 Railroad Ave. 8. Date of Birth (Month, Day, Dec. 14 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 M 208 F Dec. 195 2 Maryland 53 Director 214-60-7666 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County Itam 27 is markad other than "natural", or Itama 23a or 28a-f abov other traumatic avent, the Madical Exeminar must be notified at 12 Yes 2 No St.Michaels Direct Marvland Talbot 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21663 106 Railroad Ave. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ified within 72 hours after de Hygiene. othar than "natural", or itam 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: 2 Black 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Waitress 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill thent of Health and Mental Hitam 27 is marked others. Be Lillian Sawell Charles Edward Gale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 29 S. Locust Lane, Easton, Maryland 21601 <u>Lillian Rosalee Gale, Mother</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Dispositio 1 Burial 2 Cremation 3 Removal from State rtment o ortant: If injury ŏ *4 □ Donation 5 □ Other (Specify) Richards Memorial Pk. 01-07-2006 Easton, Maryland 21. Signature of Franki Service Licenses 22. Name and Address of Facility Bennie Smith Funeral Home 426 Dover Street, Easton, Maryland 21601 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. at caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the dise Immediate Cause (Final disease or condition resulting in death) Cardie Viscular disease Physician Interiosclerite /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ certificate has been signification, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 No After.

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the funeral director, p or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 sidence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification; To 1 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Dira filled in within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier completely (Check only one) 29d. Pate signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number mos 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mep KOPROWSK lado 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 2006 Registrar

	_ 1	For State Registrar	State of Man		rtificate of Death		Reg. No. 0	b UIZUE
ysiciar Vledica	al -	Dora Elizabe A. Facility Name (If not institution, give 1. Decedent's Name (If not institution, give	th Goins		Ab City Town and acceptant	2. Date of De Month Januar	ry 7, 200	
amine		Harford Memoria 5. Social Security Number 6. S	l Hospital	In yrs. last birthday	4b. City, Town, or Location Havre de Gi If Under 1 Year If Under	cace	4c. County of	ord
eral ctor		-	1 M 2X F	85 Yrs.	Months Days Hours	8. Date of Bir Min. (Month, Da OCt. 2	, 1920 /	9. Birthplace (State or Fore Country) ARY/AND
tified at	ctor	MD 10b. County Harfo:		oc. City, Town or L Aberde				10d. Inside City Lim 1 X Yes 2 ☐ I
ust be no	ai Director	10e. Street and Number 432 Dorsey Street	et		10f. Zip Code 21001		10g. Citizen of W U.S.	
Examinar m	by Fur	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:		Was Decedent of Hispanic Orl If Yes, specify Cuban, Mexican 1 ☐ Yes 2 XNo Specify:			- American Indian, , White, etc. Black
e Medical	Completed	15. Decedent's El (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	edent's Usual Occupation a kind of work done during mos DO NOT use retired)	it of working	16b. Kind of Bus	
rtic event, the	To Be Co	12 17. Father's Name (First, Middle, Last, Samuel Giles	0	Maid		er's Name (First, Middle,	Houseke	
er trauma		19a. Informant's Name/Relationship (Charles R. Goins	**		ing Address (Street and Number Dorsey St., A	ar or Rural Route Numberdeen, Ma		State, Zip Code) 21001
any injury or other traumatic event, the Medical Examinat must be notified at once. To Be Commissed by Euneral Diseases.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif. 21. Signature of Funeral Service Licer	Removal from State (y)	YT CALVI	RY CH. CEM.	Date / 14/06	Aberde	en MD,
		LUWKILAN	Up Ungle	sper	^{2. Name and Address of Facility} Tarring–Cargo Aberdeen, Mary	Tuneral Hon land 21001	-3399	
ian ical iner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	uplications that caused the one cause on each line. a. Due to (or as a co	death. Do not en	Tarring-Cargo Aberdeen, Mary ter the mode of dying, such as	land 21001	-3399	Approximate Interval Batween Onser and Death
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	0	વને	Decedent's Name (First, Middle, Last)			timouto or E		2. Date of Deat		3. Time of Death
	Physici /Medic		David Scott Gar	rlich Sr.				January	11^{pay} , 2006^{r}	9:00 A. M
}	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or		ath	4c. County of Death	-1
			11 W. Baltimore St 5. Social Security Number 6. Sex		rs. last birthday)	Hager	stown If Under 24 Hr		Washing	
	Funeral Director			M 2□F 71	Yrs.	Months Days	Hours Mir		Year) 9. Birth	place (State or Foreign ntry) Sylvania
	ס		Usual Residence of Decedent					- F	Feinis	syrvania
	shov	ž	10a. State 10b. County		City, Town or Lo	ecation				Od. Inside City Limits
	28a-f	Director	Md. Was	hington	Hage	10f. Zip Code			Og. Citizen of What Cou	1X Yes 2 □ No
	3a or		11 W. Baltimore S	+ an+ 010			21740			ntry ?
	death	Funeral		Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of His If Yes, specify Cubar		Specify Yes or No-	U.S.A 14. Race - Americ	
36	within 72 hours atter death with the Maryland ene. Than "naturel", or tlems 23a or 28a-f show he Medical Exam artinuation in diffied at	by Fu	1 Never Married 2 Married	1 X Yes 2 □ No If Yes, Give		1 ⊟Yes 2 🖾 No	Specify:	nto rican, etc.)	Black, White, Specify: V	etc. Nhite
5-0036	tural'	ed b	3 ☐ Widowed 4 ☐ Moivorced	Year or Dates:	16a Dece	dent's Usual Occupa	tion			
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2121	filed wit Hygiene other the	Completed		4	V	Voodworker	•		Cra	afts
and	ld be fill ental Hy ked oth ic even	Be	17. Father's Name (First, Middle, Last)	1-				ame (First, Middle, M	•	
aryland	should be nd Mental marked c	မ	Herman Garli 19a. Informant's Name/Relationship (Typ		10h Mailir	ag Address (Street a		ne'e Jean	City or Town, State, Zip	
≥	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiens. If Health and Mental Hygiens "natural", or Items 23a or 28a-f show other treumetic event, the Medical Exambra invalue the colline of a		Jennifer J. Buckle						n_{i} D.C. 200]	
altimore,	es 1 a of Hea		20a. Method of Disposition	1	. Place of Dispo	sition (Name of natory or other place) T	Date 2	Oc. Location - City or To	own, State
Ĕ	Pages ment of ent: If it iury or o		1 ☐ Burial 2 🕅 Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Sn		g Cremato	l nan	2006	Smithsburg,	Md.
Ball	permit. Pages Department of Importent: If is eny injury or o		21. Signature of Funeral Service License	8		. Name and Address			25 Bradbury	
		\triangleleft	23a. Parti. Enter the disease, or complic	ations that caused the de	ath Do not ent	L. Davis	Funeral	Home Smi	thsburg, Md.	21783 Approximate
1	Pnysi cia n /Medical		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	a cause on each line		Tie he			, , , , , , , , , , , , , , , , , , ,	Interval Between Onset and Death
	Examiner		Sequentially list conditions, b.	Due to ter as a cons	els m	ellitos			>.	5 Jears
7	nsit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):	aston	ALL	earl	*	E Tomal
a î	exect an and rial-tra	Examin	that initiated events c. resulting in death) Last	Due to (or as a conse	equence of):	viny	noc			s feet
9/8 8/90	cate be executed physician and the burial-transit	dicai	d.							
			IF FEMALE:	c. If yes, outcome of preg	in a now					-
X R Q	death certifii e attending p	Physician/Me	in the past 12 months?	1 Live birth 2 ☐ Fe 4 Pregnant at time of	ital death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
j.		hysi	1 Yes 2 No 9 Unknown	9☐ Unknown		, o (spee.,) /				
cords, r	es this gned be de	by	Part II. Other significant conditions cont	ributing to death but not re	esultion in the un	aderlying cause giver	n in Part I.		acco use contribute to th	e cause of death?
eco	> 40	ompieted						24a. Was an	24b. Were autor	osv findinos available
Ï	m = 0	omi						autopsy performe	ed? prior to condeath? ☐ No 1 ☐ Yes	osy findings available inpletion of cause of
Vital	sicien: The certificate l rector, pag	BeC	25. Was case referred to medical examiner?					ath (Check only one)		20110
6	Z .≅ ₽	To.	1 ☐ Yes 2 ☐ No Ho 27. Manner of Beath	ospital: 1 ☐ Inpatient 2 I 28a. Date of Injury	ER/Outpatien		4 Nursing r		ce 6 ☐Other (Specify)
	ng fter ine	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injury : Work? M 1 7	es 2 🗆 No	28d. Describe how	vinjury occurred	
DIVISION	Attendii er death. rector: Al by the fu	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre			28f. Location (Stre	et and Number or Rural	Route Number,
5	itel or rrs afte rel Dir led in	O						City or Town,	,	
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ft	edicai	29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examine	cian: To the best of my ki er: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the time estigation, in my opin	, date and place nion, death occu	e, and due to the cau urred at the time, dat	ise(s) and manner as sta e and place, and due to	ated. the cause(s)
	To the comp	Ž	29b. Signature and title of certifier	4. (4:0		29ç, License	number	290	d. Date signed (Month, L	Day, Year)
		+		HV, MI)	am 200 / Tuna	1 234	0655	J	AN-13, 3	2006
	3		30. Name and address of person was comed and address of person	repleted cause of death (Ite		1e 200.	HAG	en Stown,	MD 21	740
:	Sta Registra		JAN 2 0 2006	32. Registrar's Sign	Ialura		V			

			For State Registrar	State of Mary		artment rtificate			nd Me		iene eg. No. 006	01208
	9	*	1. Decedent's Name (First, Middle, Last)						2	2. Date of Deat		3. Time of Death
	Physici /Medic		Edward Lee	Hale						Month Jan 2	Day Year	5:50 a ^M
	Examin		4a. Facility Name (If not institution, give stre	et and number)		4b. City, T	Γο w n, οι	Location of	Death		4c. County of Deat	
			4326 Maple Gro	ve Road		Har	mpst	tead			Carrol	L
	Funeral		5. Social Security Number 6. Sex	005	yrs. last birthday)	If Under	1 Year Days	If Under 24 Hours	4 Hrs. g	B. Date of Birth (Month, Day,	Year) 9. Birtl	nplace (State or Foreign untry)
	Director		220-40-6430	6.	2 Yrs.					08-20-		ryland
	and w	1	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or La	cation						10d. Inside City Limits
	Manyl f sho led a	ō	MD Carrol	7	Ham	pstea	Ьe					1 ☐ Yes 2 No
	the 28e	Funeral Director	10e. Street and Number		110111	10f. Zip				1	0g. Citizen of What Co	untry?
	3a ou		4326 Maple Gro	ve Road			2	L074			IIC A	
	ms 2	Jere		Was Decedent Ever	in U.S. 13.	Was Decede			in? (Speci	ify Yes or No- ican, etc.)	USA 14. Race - Ame	
9	after or Ite		1 Never Married Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	1	ır res,speci 1 ∐ Yes 2		Specify:	Puerto Ai	ican, etc.)	Black, White	o, etc.
21215-0036	72 hours after death with the Maryland naturel', or Hems 23a or 28e-f show Steal Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:		103 2	85-1 140	Specify.			Specify: Wi	nite
5	natu	Completed	15. Decedent's Educat (Specify only highest grade c		16a. Dece	dent's Usual kind of work	Occupa k done d	ition <i>Juring most d</i>	of working	,	16b. Kind of Business/	ndustry
12	within ene.	dm	Elementary/Secondary (0-12)	College (1-4or 5+)							Constr	iction
	e fited Il Hygie other vent, III		17. Father's Name (First, Middle, Last)		rrev	ator	Cor	1Stru 18. Møther			Maiden Sumame)	1001011
an	ould be Mental arked o	To Be	Robert Laur	Hale				Но		Lenor		fer
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or litems 23a or 28e-f show or other treumatic event, the Modical Examiner must be notified at	-	19a. Informant's Name/Relationship (Type)		19b. Mailir	ng Address	(Street a				, City or Town, State, Z	
	s 1 and 2 of Health a item 27 ls other tree		Diane D. Hale -	Wife	4326	Map]	le G	rove	Rđ.	Ham	pstead, N	ID 21074
altimore,	item item		20a. Method of Disposition		Ob. Place of Dispo	sition (Nam	e of		Dat		20c. Location · City or	
E	Pages nent of I ant: If ite		1 ☐ Burial 2 ☑ Cremation 3 ☐ Rem '4 ☐ Donation 5 ☐ Other (Specify)	loval from State	Car	roll		· 1	-3-0	06	Hampstead	i MD
att	permit. Pages Department of Importent: If i any injury or o		21. Signature L Funeral Service Licentee			2. Name and	Addres	s of Facility	Fl i		neral Hom	
<u> </u>	89 = 9		Tally Xta	its mod	0550 9	34 S.	. Ma	ain s	t.,	Hamps	tead, MD	21074
P			23a. Part1. Enter the sease, or complica shock, or heart failure. List only one	ions that caused the cause on each line.	death. Do not ent	er the mode	of dying	g, such as ca	ardiac or i	respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	60	149 6	2464	-					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of):							
		<u></u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a cor	nsequence of):			_	****			
	ted nsit	nin	Cause (Disease or injury	200 10 (01 00 0 00							1	
,	execun n and ial-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a cor	nsequence of):							
8760,	cate be executed oblysician and the burial-transit	edical	L d									
68	death certificate be executed e attending physician and of for use as the burial-transit	Medi	15.551.44.5									
Box	eath certific attending pl	an/h	23b. was decedent pregnant	If yes, outcome of pr		Ectopic pre	egnancy				23d. Date of deli	•
Э.		Physician/M	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \) 9 \(\subseteq \text{Unknown} \)	4☐Pregnant at time 9☐ Unknown		Other (spe					Month	Day Year
P.O.	law requires that the de as been signed by the a 2 should be detached t		Part II. Other significant conditions contri	outing to death but no	at regulting in the u	ndorhving og	uico aiva	o in Part I		23e Did tob	pacco use contribute to	the rause of death?
ds,	ires tha signed I d be det	by	Multip	-		inderlying ca	1030 9140	mini atti.			es 2 No 3 Pro	
Ö	w require been sig should b	etec	· · · · · · · · · · · · · · · · · · ·					-		04- 146	045 146	
of Vital Records,	0 5 0	Completed								24a. Was a autops perform	v prior to c	opsy findings available ompletion of cause of
a			OF Man ages referred to modical						(5 1 /	1 ☐ Yes 2	Yes 1 ☐ Yes	2 No
⋚	Physicien: this certific al director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	pital:	2 ER/Outpatier	nt 3□ DO/	_A Othe			Check only on	e) ince 6 □Othe <i>r (Spe</i> d	(64)
of	g Phys er this eral di	F 1	27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time of		Bc. Injury Work				w injury occurred	ny)
ion	Attending Ir death.	atio	1 ★Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day 1 ed	ar) Injury	М		.r ∕es 2 🗆 No	0			
Division	l or Attenuater deat Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S)	At home, farm, str	eet, factory,	office		28	f. Location (Sti	reet and Number or Ru , State)	ral Route Number,
	ital or A											
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	dicai	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examiner	ian: To the best of my : On the basis of exa- and manner stated.	y knowledge, death mination and/or in	n occurred a vestigation,	it the tim in my op	e, date and inion, death	place, an occurred	d due to the ca I at the time, da	tuse(s) and manner as ate and place, and due	stated. to the cause(s)
	To the To the To the Somple	Me	29b. Signature and title of certifier			29c.		number	· · · · · · · ·	25	9d. Date signed (Month	, Day, Year)
)	WIN		I Howel Su	nif. M. 9.			D 1.	רנרני ל	4		1/3/06	
	M.9-		30. Name and address of person who com		(Item 23a) (Type,	Print)	+4 ~	J'r.	W.	itmin.	ster, md.	21157
	Sta	te.	31. Date filed (Month, Day, Year)	32. Restrar's S	Signature	_						
	Registr		JAN 0 4 20	06 Slow	· A	borte	1					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** R. HANKERSON JAN. 1, 2006 3:15 P [™] ANNIE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 11408 HONEYSUCKLE CT. PRINCE GEORGES UPPER MARLBORO If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 XF Yrs. 1941 FLORIDA Director 267-56-7297 64 4, Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 27 is marked other than "natural; or items 23a or 28s-f show traumatic event, the Madical Experience must be notified at 1X Yes 2 No Director MD. PRINCE GEORGES UPPER MARLBORO 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 11408 HONEYSUCKLE CT. U.S.A. 20774 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: BLACK 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HEALTH CARE WORKER STATE OF MARYLAND 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HANKERSON LUCILLE CHEE MACK 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. HANKERSON/DAUGHTER 1006 FALLCREST CT., MITCHELLVILLE, MD. 20721 ROCCI 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of I
Important: If ite
any injury or ot 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 1-5-2006 RIVERDALE, MD. 21. Signature of Funeral Service Licensee CHAMBERS FUNERAL HOME & CREMATORIUM, P.A MO0091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** OPROX 19.20 /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Physician/Medical as the attending use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? certificate 2 No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ပ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending 2 🗆 No death. 1 🗌 Yes investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide 24 hours a Funerel (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie MUNIC onyany ٥

Baltimore. Maryland 21215-0036

Box 68760.

P.O.

Records,

State Registrar

LAPENTA, M.D. 445 DEFENSE HIGHWAY, ANNAPOLIS, MD. 21401 MICHAEL 31. Date liled (Month, Day, Year) 2. Registrar's Signature JAN 04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1 = For State Registrar		of Marylar			t of H	ealth a	and N		eg. No	06	01210
П	Physic	ian	Decedent's Name (First, Middl				TD				2. Date of Dea Month	th Day	Year	3. Time of Death
	/Medi		4a. Facility Name (If not institution	GEORGE V		HAUVER	1	Tour	Location of	4.0	Jan		ty of Death	12:48 M
	Examir	ner	Washington Cou	. 9				erst		oi Deatii			ingto	
	Funeral		5. Social Security Number	6. Sex 1 2 M 2 ☐ F		. last birthday)	If Under	1 Year	If Under		8. Date of Birth		9. Birth	place (State or Foreign
or go	Director		214-36-0186	1 ፭ ⋅M 2□ F	7	O Yrs.	Months	Days	Hours	Min.	8. Date of Birth Month, Pay May 24,	1935	Mar	yland
1	and		Usual Residence of Decedent 10a. State 10b. County		10c, C	ity, Town or Lo	cation						1	10d. Inside City Limits
	Maryl f ehc	ō	Maryland Fred	oriok		Freder								1 ☐ Yes 2√ No
	r 28a	Director	10e. Street and Number	ELICK	,	rreder.	10f. Zip	Code			1	0g. Citizen o	f What Cor	
	h with		11524 Gambrill	Park Roa	ad		2	2170	2				.S.A.	•
	eme Em	Funeral	11. Maritat Status		ecedent Ever in U	J.S. 13.	Was Deced	ent of His	spanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)	14. R	ace - Amer lack, White	ican Indian,
36	s afte	by Fu	1 Never Married 2 Marr	If Yes, (2 □ No Sive		1 ☐ Yes 2		Specify:			Spec	ifu:	
21215-0036	n 72 hours after death with the Maryland "natural", or fleme 23a or 28a-f ehow utical Evantinal must be rectified at	ed b	3 ☐ Widowed 4 ☒ Divorced	Year or	Dates:	162 Docor	dent's Usua	l Occurre	tion				WII	ite
15	- 3	Completed	(Specify only higher	st grade complete		(Give	kind of wor DO NOT us	k done d	lurina masi	t of work	ing	16b. Kind of	Business/I	ndustry
212	d within giene.	mo.	Elementary/Secondary (0-12)	College	(1-4or 5+)		Park H	Range	er			Gamb	rill	Park
pu	be filed ntal Hygi of other event, II	Be	17. Father's Name (First, Middle,								e (First, Middle, i	Maiden Suma	ame)	
yla		P_	George William								Ridenour			
Maryland	C1 00 = 00		19a. Informant's Name/Relations George Hauver		1						al Route Number ad, Fred			
	ges 1 and 2 to 6 Health If Item 27 or other tr		20a. Method of Disposition			Place of Dispo					-	20c. Location		
Baltimore,	Pages nent of int: if it		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		n State	cemetery, crer • Moria	natory or ot	her place			56		-	ryland
altir	그 문문를 .		21. Signature of Funeral Service			_								
ä	Depa Depa impo eny ir		1 de	- In	7						SON FUN			
			23a. Parn. Enter the disease, or shock, or heart failure. List	complications that	caused the dear	th. Do not ent	er the mode	of dying	, such as	cardiac o	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Vontre	01100	6	lrs.	hit	1				Onset and Death
4.	/Medical Examiner		resulting in death)	Due to	o (or as a consec	quence of):			de					
П	LAGITITION	<u></u>	Sequentially list conditions, if any, leading to immediate	b	(U) as a consec	V 2-46								-
	nsit	nlne	cause. Enter Underlying Cause (Disease or injury	0000	01 23 2 0011380	(uerice or).								
Ć.	execu in and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to	o (or as a conseq	tuence of):			_				_	
8760,	icate be executed physician and s the burial-transit	cal		d										
89	ndiffica ng ph		IF FEMALE:											
Вох	ealh certific attencing p	Physician/Med	23b. Was decedent pregnant in the past 12 months?		utcome of pregna birth 2 Peta		Ectopic pre	gnancy					ate of deliv	
o ·	the a	/slc	1 Yes 2 No	4□Preg 9□Unk	nant at time of d	leath 5□	Other (spe	ecity)					lonth	Day Year
P.O.	The law requires that the death certific ate hes been signed by the attending pigge 2 should be detached for use as t		Part II. Other significant condition	ns contributing to	death but not res	ulting in the ur	nderlying ca	use aive	n in Part I.		23e, Did tob	acco use cor	atribute to t	the cause of death?
Records,	uires n sign	d by	Cent 7	alune			, ,					s 2 No	3 Pro	
00	w requir s been si should	lete									24a. Was a	24h	Were aut	opsy findings available
Re	The lay te hes age 2	Completed									autops perforn	ned?	prior to co death?	empletion of cause of
Vita	iician: Th certificate rector, pag	BeC	25. Was case referred to medical		440 T			-	26. Place	of Death	1 Yes 2	. ⊠No	1 🗆 Yes	2 No
<u>></u>	Physic this ce	To E	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatien	3 DO	04.			me 5 🗆 Reside		her (Speci	fy)
Č	ding P h. After t funera		27. Manner of Death 1 ☑Natural 5 ☐ Pending		of Injury nth, Day Year)	28b. Time of Injury	28	c. Injury Work	at ?	4	28d. Describe ho	w injury occu	rred	
Sio	ttend death stor: /	cat	2 Accident investig	ation			М		es 2 N					
Division of	or A after Direction by	Certification:	4 Homicide determi	Dod 200. Flat	e of Injury - At hi ding, etc. (Specif	ome, tarm, stre by)	eet, factory,	office			281. Location (Sti City or Town	eet and Num , State)	ber or Run	al Route Number,
	24 hours 25 hours Funerel etely filled		29a. Certifier 1 Certifyin	g Physician: To th	e best of my kno	wledge, death	occurred a	t the time	a date and	l place a	and due to the ca	use(s) and m	20001 200	tated
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only 2 Medical I	exeminer: Op-ine	basis of examina nner stated.	ition and/or inv	estigation, i	in my opi	inion, deat	h occurre	ed at the time, da	ite and place	, and due t	o the cause(s)
	To the To the comp	Σ	29b. Signature and title of certified	1			29c.	License	number		25	d. Date sign	ed (Month,	Day, Year)
١,			lan	/				D 5	703	6.2		1 - 2	2 - 0	6
1	U		30. Name and address of person	who completed cau	use of death (Item	n 23a) (Type, I	Print)		00	1	1. 41	/		,
All		N	31. Date filed (Month, Day, Year)	20	22911 Benjamara Sia	Jeff	resi	7	13h	V .	much	burg	/hc	21783
1766	Sta Registr		· ·	5 2006	Registrar's Signa	K	Local	11				/	t.	
	10 to 10	-3.5	JAN	1 2 2040	MARK	100	OC MAN	Page 1						

		1 - For Stete Registrar	State of N	laryland / D		artmen <i>tificate</i>			and M		iene	06	012	Britishpana B
Physic	ian	1. Decedent's Name (First, Middle, Last	,							2. Date of Deat Month	Day	Year	3. Time o	of Death
/Med Exam		James Carl Hale 4a. Facility Name (If not institution, give Atlantic General	street and numbe	r)		4b. City,		Location of	of Death	1	1	2006 unty of Death orces		A [™]
Funera Director		5. Social Security Number 6. Se 218-14-0479		83 Y	rday) rs.	If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, 10 / 26 /	Year)		nplace (State untry)	or Foreign
ith the Maryland or 28e-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD Worces 10e. Street and Number	ter	10c. City, Town		cation	Code			10	Og Citizon	of What Cou		City Limits s 2 X No
5-0036 72 hours after death w natural', or Itams 23a	by Funeral	11003 Grays Corne 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced 15. Decedent's Edu (Specify only highest grad	12. Was Deceden Armed Forces NOTYes 2 If Yes, Give Year or Dates	t Ever in U.S. ?] No . 1942-46	Dec <i>e</i> d	21	811 ent of His ify Cubar	Specify:		ocity Yes or No- Rican, etc.)	14.	Race - Amer Black, White	nican Indian, b, etc. White	
CA DOP	Be Completed	Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last)	Colleg <i>e</i> (1-40)	5+)	life. [e Off	e retired) icer			(First, Middle, M			rcemer	<u>nt</u>
	ToB	Charles Hale 19a. Informant's Name/Relationship (T)	/ре, Print)	19b.	Mailin	g Address	(Street a			Unkno		wn, State, Zi	ip Code)	
or Healt		Carl J. Hale (son	Removal from State	20b. Place of I	003 Dispos	Gra sition (Nam natory or ot	ys (e of her place	Corne	r Ro	d. Berl	in I	MD 218 on - City or T	811 own, State	
Baltimo permit. Pag Department Important: I any injury o		21. Signatur of the Figure 1. Service Licens	ee Infar	Cape	22.	Name and	Address illian	s of Facility n St.	Th , Be	e Burba erlin, MI	age F D 218	kford unera 111	, DE Il Home	e
Frysician /Medical Examiner		23a. Parf. Enter the disease, or compi shock, or heart faflure. List only of Immediate Cause (Final disease or condition resulting in death)	a	ed the death. Do not line.	<i>i</i>		A	t, such as o		r respiratory arre	st,		Approximat Interval Bel Onset and	tween
8760, cate be executed bhysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate Eart In Jurying Cause (Disease or injury that initiated events resulting in death) Last	J	s a consequence of										
BOX 6 death certifi e attending I d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Fetal death at time of death		Ectopic pre Other <i>(spe</i>					- 1	Date of deliv Month		Year
Cords, P.O w requires that the been signed by th should be detache	by	Part II. Other significant conditions con	ntributing to death	but not resulting in t	he un	derlying ca	use giver	n in Part I.		23e. Did toba			the cause of d	
I Rec The law ate has b	Completed									24a. Was an autopsy performe		b. Were auto prior to co death? 1 Yes	opsy findings empletion of c	available ause of
Phys Phys This	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1 Inpat 28a. Date of Inj (Month, D.				Other c. Injury a Work?	4 □ Nurs	sing Hom	(Check only one,	ce 6 □(fy)	
i girling	Certification;	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At home, farm tc. <i>(Specify)</i>	n, stre	et, factory,	office		2	8f. Location (Stre City or Town,	et and Nu State)	mber or Rura	al Route Num	ber,
tha Hospital hin 24 hours a the Funeral I	edical	29a. Certifier 1 Certifying Physical Check only 2 Medicel Exeminates	sicien: To the best ner: On the basis of and manner s	or examination and	death or inve	occurred a estigation, i	t the time n my opii	, date and nion, death	place, ar occurre	nd due to the cau d at the time, dat	se(s) and e and plac	manner as s e, and due to	stated. o the cause(s	;)
To tha within 2 To the complet	Σ	29b. Signature and title of certifier	UK	- D.	0.		License	15.0	3			ned (Month,		
1.6+1		30. Name and address of person who co	empleted cause of	death (Item 23a) (Ty 2733 H rar's Signature	ype, P	rint) //h u	14	Du	ir	Be	1.	, m,	۵	
Sta Regist		31. Date filed (Month, Day, Year)	32. sist	rar's Signature	4	ande	61							

			1 _ State	State of	Maryland / Dep	partment of Headertificate of De		ntal Hygien	e 006	01212	
			Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death							3, Time of Death	
	Physici			ora Hende	**COD			Month Day Year			
}	/Medic Examin		4a. Facility Name (If not institution			4b. City, Town, or Lo		January 3, 2006 5:20 A M			
	Exami		Northampton Mar	or Nursin	o Home	Frederic	k	F	rederick		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last birthda	/) If Under 1 Year If		Date of Birth (Month, Day, Year		place (State or Foreign	
L	Director		372-34-3680	1 □ M 2X F	84 Yrs.	Worth Days		et. 22, 1	921 Ire	land	
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	ocation				10d. Inside City Limits	
	Maryl	ğ	W Jeffer	tson						1 ☐ Yes 2X No	
	the r 28a	Je C	10e. Street and Number	. 5011	Harpers	10f. Zip Code		10g. C	itizen of What Cour	ntrv?	
	3a ou	0	24 Hickorywood	Court		25425			USA		
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, Itla Medical Examinat must be notified at	Funeral Director	11. Marital Status		dent Ever in U.S. 13	. Was Decedent of Hispa If Yes, specify Cuban, I	anic Origin? (Specify	Yes or No-	14. Race - Americ		
98	or Ite	교	1 ☐ Never Married 2 ☐ Marri		217 No		mexican, Pueno Ric Specify:	an, etc.)	Black, White,	etc.	
21215-0036	ural',	Completed by	3 Widowed 4 □ Divorced	Year or Da	tes:				Specify: Wh	ite	
5	n 72	lete	15. Decedent (Specify only highes	's Education t grade completed)	(Giv	edent's Usual Occupation Se kind of work done duricus DO NOT use retired)	on ing most of working	16b. I	Kind of Business/In	dustry	
12	withi ene. than	duc	Elementary/Secondary (0-12)	College (1-	4or 5+) Cler	_		Do	tail Sale		
	Hygi Hygi other	Be C	17. Father's Name (First, Middle, I	_ast)	CTel		3. Mother's Name (F			es	
Maryland	lental ked i ic ev	To B	John Nelson				Margaret S	Smith			
ary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, It Medical Examinat must be notified at once.	_	19a. Informant's Name/Relationsh	nip (Type, Print)	19b. Mai	ling Address (Street and			or Town, State, Zip	Code)	
-	and 2 salth a n 27 i		June Leonard -	Daughter	24 F	lickorywood	Court - H	largers F	erry. WV	25425	
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 Demoval from 9	20b. Place of Disp	osition (Name of ematory or other place)	Date		ocation - City or To		
altimore,	Pag ment ant: I ury o		'4 □ Donation 5 □ Other (Sp		Hagersto	wn Cremator	cy 1/7/06	Has	erstown.	MD	
Ball	Depart Import any in		21. Signature of Funeral Service I	icensee		22. Name and Address o	of Facility Eack]		er Funera		
	70 = 4 0	-	Rolut I. s	Jenen	M970		Harpe	rs Ferry	, WV 2542	25	
	Inysician /Medical Examiner		Approximate shock, or heart failure. List only one cause on each line.								
		disease or condition							Onset and Death		
		edical Examiner	,	Due to (d	Due to (or as a consequence of) COLONAY as tay disease						
			Sequentially list conditions, if any, leading to immediate	b. Due to (d	b. Due to (or as a consequence of):						
	d d ansit		cause. Enter Underlying Cause (Disease or injury that initiated events	0			U	U			
o,	an an rial-tr		resulting in death) Last	or as a consequence of):							
8760,	ficate be executed physician and is the burial-Iransit		d								
9	eath certific attending p		IF FEMALE:	1							
Вох	death certif e attending d for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live bit		□Ectopic pregnancy			23d. Date of delive Month	Day Year	
o.	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unkno		Other (specify)				,	
<u> </u>	The law requires that the te has been signed by the oage 2 should be detached	/ Ph	Part II. Other significant conditio	ns contributing to dea	ath but not resulting in the	underlying cause given in	n Part I.	23e. Did tobacco	use contribute to th	ne cause of death?	
Records,	w requires that been signed I should be det	d by						1 ☐ Yes 2	. □No 3 □ Prob	ably 4 Unknown	
<u>o</u>	w req	Completed						24a. Was an	24h Were auto	osy findings available	
	The lav	duc						autopsy performed?	prior to cor death?	npletion of cause of	
Vital		0	25. Was case referred to medical			26	3. Place of Death (C)	1 Yes 2 No	1 □ Yes	2∐ No	
<u> </u>	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 □ In	patient 2 ER/Outpatie	Other	4 ♥ Nursing Home		6 ∏Other (Specify	()	
0	ng Ph ter th		27. Manner of Death	28a. Date of	Injury 28b. Time , Day Year) Injury	The same of the sa	and the same of th	Describe how inju		/	
0	endir eath. or: Af he fu	atic	1 XNatural 5 ☐ Pending 2 ☐ Accident investig	ation	,,,		2 □ No				
Division of	r Att	ertification;	3 Suicide 6 Could n 4 Homicide determi	and 288. Place	of Injury - At home, farm, s g, etc. (Specify)	treet, factory, office		Location (Street ar City or Town, State	nd Number or Rura. e)	l Route Number,	
	urs af	0		1							
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director,	edical	29a. Certifier (Check only one) Certifying (Check only one)	Physician: To the to yenther. On the base and manner	pest of my knowledge, dea sis of examination and/or i	th occurred at the time, onvestigation, in my opinion	date and place, and on, death occurred a	due to the cause(s t the time, date an) and manner as st d place, and due to	ated. the cause(s)	
	o the o the omple	Med	29b. Signature and time of certifier	and marine	or stated.	29c. License nu	ımber	29d. Da	ite signed (Month, L	Dav. Year)	
	1		1		110	DS	18291		1-04	nla	
	4		30. Name and address of person	no completed cause	of death (Item 23a) (Type	, Print)		Λ	<u> </u>	21701	
_			SAJJAD	/A212	MD. 8	0) Tall	House	Ave.	treden	el. Mi	
	Sta		31. Date filed (Month, Day, Year)	2006 32. 5	gistrar's Signature	Society !	-			21701	
	Registr	ar	JAN 0 4	7000	MANO NO Y					- , , 0	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene 0 1 6 0 1 2 1 3

		•	For State Of Ma		artment of Health and r rtificate of Death		j. No.	U I ba I U	
4	Dhualai	P	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death	
30	Physicia /Medic		Dolores Mary Haag		January		10:12 P.M		
	Examin	er	4a. Facility Name (If not institution, give street and number)	_	4b. City, Town, or Location of Death	1	4c. County of Death		
7		* 4	Montgomery General Hospita 5. Social Security Number 6. Sex 7. Ag	1 e (In yrs. last birthday)	Olney II Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgom		
	Funeral Director		577-38-8306	75 Yrs.	Months Days Hours Min.	June 27,	1930 New	place (State or Foreign ntry) York	
	D		Usual Residence of Decedent						
	arylar show	<u>.</u>	10a. State 10b. County	10c. City, Town or Lo	sville		1	10d. Inside City Limits 1 ☐ Yes 2X No	
	he M	ectc	Maryland Frederick 10e. Street and Number	LJam	10f. Zip Code	10.	g. Citizen of What Cou		
	with with	١	11402 Meadowlark Drive		21754		U.S.A.		
	death me 2:	by Funeral Director	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S II Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Americ Black, White,		
9	after or tte	Fu	1 Never Married 2 Marned 1 Yes 2 1	No	1 ☐ Yes 2√2 No Specify:	o moan, etc.)	Specify:	etc.	
99	filed within 72 hours after death with the Maryland Hygiene. yther then "natural", or tteme 23a or 28a-f show ent. The Medical Examiner must be notified at	d b	3 Widowed 4 Divorced Year or Dates:		dent's Usual Occupation	1	Whi 3b. Kind of Business/In		
15	in 72	olete	15. Decedent's Education (Specify only highest grade completed)	(Give	kind of work done during most of wor DO NOT use retired)	king	D. Killo of Edailleas	adatiy	
212	d with giene.	Completed	Elementary/Secondary (0-12) College (1-4or 9	Home	maker		Own Home		
Maryland 21215-0036	al Hy d other	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, M			
yla	Ment Ment	2	Frank P. Harrison	401 14 15	Mary			- Codo)	
Mar	d 2 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Type, Print)	Ŷ	ng Address <i>(Street and Number or Ru</i>)2 Meadowlark Driv			yland 21754	
	Heall Heall tem 2		William A. Haag, Jr Son 20a. Method of Disposition		osttion (Name of matory or other place)		oc. Location - City or T		
OE E	Pages ent of nt: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify)		Memorial Gardens	1/6/06	rederick,	Maryland	
Baltimore,	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 271s marked other then "natural", or Iteme 23s or 28a-f show any injury or other traumatic event. The Madical Examiner must be notified at once.		21. Signal are of Fulleral Service Licensee) 22	2. Name and Address of Facility				
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1			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	the death. Do not entine.	ter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onget and Death	
a	Physician	Immediate Cause (Final disease or condition resulting in death)							
1	/Medical Examiner		Due to (or as	a consequence of):	MEZLITUS			ream	
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequence of):	1016 661/03			Car	
	outed id ansit	Examiner	cause. Enter Underlying Cause (Diseese or injury that initiated events c						
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68760,	ificate be executed g physicien and as the burlat-transit	edical	d						
-	± On ei		IF FEMALE: 23c. If yes, outcome		⊒Ectopic pregnancy		23d. Date of deliv	ery	
Вох	that the death cer ed by the attendir detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant a		Month	Month Day Year			
O.	tt the d by the tached	hys	9 Unknown						
s, P	w requires that the s been signed by th should be detache	by	Part II. Other significant conditions contributing to death b	out not resulting in the u	Inderlying cause given in Part I.		acco use contribute to t		
ord	requir een si eould	ted	URITURICY TIGHT	1701 6	97070		1 Yes 2 140 3 Probably 4 Unknown		
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sior	Attending ir death.	atio	2 Accident investigation	,,,,,,,	M 1 Yes 2 No	5 2 □ No			
Division	l or Atten after deat Director:	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of In building, e	jury - At home, larm, st tc. <i>(Specify)</i>	reet, lactory, office	28f. Location (Str. City or Town,	eet and Number or Rur State)	al Route Number,	
٥	Hospital of the hours at Funeral Ditely filled in	ပ	29a. Certifier 1 Certifying Physician: To the best	of my knowledge, deal	th assured at the time, date and place	and due to the on	usa(s) and manner as	rinted	
	Hospital 24 hours a Funeral I letely filled	edical	(Check only one) 2 Medical Exeminer: On the basis of and manner st	f examination and/or in					
	To the Hospital or Attenwihin 24 hours after deat To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier	7	29c. License number	29	d. Date signed (Month,	Day, Year)	
	10			- M	0 03842)	J,	ANUARY:	2,2006	
	10		30. Name and address of person who completed cause of	death (Item 23a) (Type	ADMOU DRIVE,	CHUEN	(DOIAL	4, 2006 MD 2090	
90	Sta	tò	31. Date liled (Month, Day, Year) 32. Rec	rar's Signature	TOPOL DETOC	711-1012	-141U 1		
	Regist		JAN 0 4 2006	alues It	anaile)				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Ma	aryland		•		teaith and i Death	wentai my	Reg. No	06	01214
г	Physicia		1. Decedent's Name (First, Middle, Las							2. Date of De Month Jan	15 ^{Day} 2	O O ^{Year}	3. Time of Death
No	/Medica	al -	Lona A. Hawk 4a Fecility Name (If not institution, give						4b. City, Town, or I			nty of Death	2:44p.m.
1	Examine	er	Moran Manor			Ctr	•		Vesternp			egan	
	Funeral Director		5. Social Security Number 6. Social Security Number 1	ex 7. Age	e (In yrs. le		day) If Un	der 1 Year hs Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 10/22	th ay, Year) 2/22	9. Birth Cou	place (State or Foreign ntry)
	end **	-	Usuel Residence of Decedent 10a. Stete 10b. County		10c. City	, Town o	or Location						10d. Inside City Limits
	Mary Fired a	호	MD Allega	ny	Ra	w1i	ngs						1 ☐ Yes 2 ☐ No
	ter death with the Maryler thems 23a or 28a-f show ner must be notified at	al Director	10e. Street end Number 22417 McMullen	Hwy.			10f.	Zip Code 2155	57		U.S.		ntry?
020	urs at	by Fur	11. Maritel Status 1⊠ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		5.			lispanic Origin? (S an, Mexican, Puerti Specify:	pecify Yes or No o Rican, etc.)		Race - Ameri Black, White, city: White	etc.
5-0	72 ho	ete	15. Decedent's Ed (Specify only highest gre	lucation de completed)		16a. D	ecedent's L Give kind of	sual Occup work done	eation during most of world)	king	16b. Kind o	f Business/In	dustry
121	filed within Hygiene. ther than int, the Me	Completed	Elementary/Secondary (0-12) 8th	College (1-4or 5	5+)		e bono omem		d)		OWD	own home	
9	Hygie Hygie		17. Father's Name (First, Middle, Last)			2.	Omem	an.el	18. Mother's Nam	ne (First, Middle			_
/lan	uld be Aentel rked o	To Be	Frank M. Hawk						Erma A.	Han1:	ln		
Maryland 21215-0020	ges 1 and 2 should nt of Health end Men if item 27 is marke or other traumatic		19a. Informant's Name/Relationship (7 Anna Layton/si	** .					and Number or Ru Llen Hwy				
Baltimore,	Peges 1 a nant of Her nt: if item iry or othe		20a. Method of Disposition 12 ☐ Gremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Ce	metery,		or otner pia		Date /18/0		on - City or To	
Balti	permit. Peges Depertment of important: if it any Injury or once.		21. Signature of Funeral Service Licent	500	.)		Mar	kwoo	ss of Facility Tunera				
		\dashv	23a. Pert1. Enter the disease, or comp shock, or heart failure. List only	plications that caused	the death.	Do not	enter the r	node of dyir	x 912, Ing, such as cardiac	or respiratory a	rrest,	0720	Approximate Interval Between
	Physician /Medical Examiner	ler.	Immediate Cause (Final disease or condition resulting in death)	a. End	's tage	٠		د ر	obstructi			Discase	Onset and Death
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P.O. Box	the de sy the ached	Physician/M	Part II. Other significant conditions co										o the cause of death?
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Division of Vital Records,	ling Physician:). After this cartific funeral director,	၉	27. Manner of Death	28e. Dete of Injur (Month, De)	ry :	R/Outpe 28b. Tim Inju	e of	28c. Injur Wor	y at	ome 5 ☐ Resi 28d. Describe			(y)
Division	To the Mospital or Attending Physician: Tha is within 24 hours after deeth. To the Funeral Director: After this cartificate ha completely filled in by the funeral director, pege:	Certification:	2-Accident investigation 3 Suicide 6 Could not be determined 28e. Place of thiuny - At home, farm, street, factor building, etc. (Specify)									al Route Number,	
	Hospital or 124 hours afte Funeral Dir letely filled in	edical C	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	ysician: To the best of inner: On the basis of and manner sta	examination	ledge, d on end/o	eath occurr r investigat	ed at the tir ion, in my o	ne, date and place, pinion, death occur	, and due to the rred at the time,	cause(s) and date and place	manner as s e, and due t	stated. the cause(s)
	within To the		29b. Signature and title of certifier					29c. Licens	License number 29		29d. Date sig	ned (Month,	Day, Year)
			an					D 2	-1244		1/16	1200	6
			30. Name end eddress of person who of Jesus H. Tan,					aza,	Frostbu	rg, MD	2153	2	
	State Registra	5	31. Dete filed (Month, Day, Year) JAN 1 9 2006	32. Registra	ar's Signatu	Jre Age	new)						

Amend item#28b, perfect of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 745 P M Harvey Irainia January 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmore Maryland Medical Center If Under 24 Hrs. 8. Date of Birth Oct. 6, 1921 9. Birthplace (State or Foreign **Funeral** Days 1 M 204 Months Hours New Jersey 153-18-0858 84 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be nutified at once. 1 Nes 2 No Talbot Easton Directo Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21601 7054 Pine Ridge Road USA Funeral 12. Was Decedent Ever in U.S. Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 Coltege (1-4or 5+) Secretary/Bookkeeper Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lucy Gladys Covert James Herbert Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7054 Pine Ridge Rd., Easton, MD James Edward Harvey/Spouse 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MidShoreCremationCenter 1/3/2006 4 ☐ Donation 5 ☐ Other (Specify) Cambride, MD Signature of Funeray Service Licensee Mid Shore Cremation Center, P.O. Box 1464, 2272 Hudson Rd., Cambridge, MD 21613 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition **Physician** Hemorrhage vanial /Medical resulting in death) Due to (or as a consequence of): Examiner Accidental Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and the for use as the burial-transit death certificate be executed NON APPROVED HY Division of Vital Records, P.O. Box 68760, TIF Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 1 Yes 2 No pege 2 should Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 □ No funeral director, Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Certification: To 1 X Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 1 Natural 5 ☐ Pending 6 P M Location (Street and Number of April Route Number, City or Town, State) 1954 (New Ridge Mend within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes investigation 31 05 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) EASTEN, MD To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 17103 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) Strayer Greene Street 32. Poistrar's Signature 31. Date filed (Month, 2006 State 5 Registrar

			State of Maryl				d Mental Hyg		01216	
			State Registrar	Cei	rtificate of	Death	2. Date of Dea	Reg. No."	O I fa. I U	
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	/Medic	al	Clarence Preston	Hai		of continuous of F	JAN	4c. County of De		
	Examin	er	4a. Facility Name (If not institution, give street and number)		తరీ. City, Town, o		Jean .			
			GLAYDE VALLEY NURSING & REHAI 5. Social Security Number 6. Sex 7. Age (In	B CTR. yrs. last birthday)	WALKERS If Under 1 Year		Hrs. 8. Date of Birth	FREDERI 9. Bi	rthplace (State or Foreign ountry)	
	Funeral Director		4MM 2□ E	2 Yrs.	Months Days	Hours	Hrs. 8. Date of Birth (Month, Day MAY 13	<i>r, Year)</i> C .1933 SAI	LEM W.VA	
			Usual Residence of Decedent							
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	aa-f s	ct C	MD FREDERICK	EMMITSBU						
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	er de Items	nue	11. Marital Status 1 □ Never Married 2 ☒ Married 1 □ Never Married 2 ☒ Married	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin an, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	Black, Wh		
36	rs aft		1 ☐ Never Married 2 ☒ Married 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: KOI	REAN	1 ☐ Yes 2 💆 No	Specify:		Specify: W	HITE	
Ş	tura stura	ed	15. Decedent's Education	16a. Deced	dent's Usual Occup	ation		16b. Kind of Busines	s/Industry	
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yla	ould by Ment	၉	WILLIAM PRESTON HAUGHT					LEDGE		
Maryland	2 sho and ds ms	1	19a. Informant's Name/Relationship (Type, Print)				or Rural Route Numbe	r, City or Town, State,	Zip Code)	
	and lealth m 27 har tu		CHARLES HAUGHT/SON	4075 0b. Place of Dispo	CARRICK	CT., E	MMITSBURG Date	MD. 21727 20c. Location - City of	r Town State	
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Baltimore,	permit. Pages Depertment of I Important: If it any injury or o		21. Signature of Funeral Service Licensee		2. Name and Addre			NERAL HOME	27	
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М			shock of heart failure. List only one cause each line.	1	66	VE	0.	. 00.,	Interval Between Onset and Death	
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	o the o the omple	Med	29b. Signature and title of certifier	-	29c. Licens	se number	, :	29d. Date signed (Mor	oth, Day, Year)	
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	()		30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print)	1	50		200	
	HI		HILD J. GILSON MD	1475	TANE	=7 AV	E Me	りァリ	21402	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's S	Signature						
	Registi	rar	JAN 1 8 2006 Kanna	H Son	roles.					

			1 - For State Registrar	State of Mar	-	epartm Certific			nd M		iene g. No.)6	01217
			1. Decedent's Name (First, Middle, Las	st)						2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medic		Norris W. Hayman,	Sr.						January	11	2006	5:15 A M
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. 0	ity, Town, or	Location of	Death		4c. Coun	ty of Death	
			Corsica Hills Nur		(1		Centre	ville	A Hrs	8. Date of Birth		een A	
	Funeral Director		5. Social Security Number 6. Sp. 120–32–9603	ex 7. Age M 2 F	(In yrs. last birth 72 Y	rs. Mon		Hours	Min.	(Month, Day, Aug 14	Year) 1933	Cou	ptece (State or Foreign htty) 7 land
			Usual Residence of Decedent		72					1146 14	1755	liary	Tanu
	yland		10a. State 10b. County		I0c. City, Town	or Location		-					10d. Inside City Limits
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	or 28	Oire	10e. Street and Number			10f	Zip Code			1	0g. Citizen o	f What Cou	ntry?
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	er de Items	Funeral Directo	11. Marital Status 1 □ Never Married 2 X Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No	er in U.S.	13. Was D	specify Cuba	ispanic Orig n, Mexican,	n? (Spe Puerto l	city Yes or No- Rican, etc.)		ace - Ameri ack, White,	
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Ma	P 5 1 2 0		19a. Informant's Name/Relationship (19arlene H. Hayman)			3104				idgely,			
	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		20a. Method of Disposition	WILE	20b. Place of	Disposition	Name of				20c. Location		
on O	ages ant of it: If If		1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify		1	horo		· 1	ອກ	15 2006	Gree	nehor	o, Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licen		Greens								
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П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	pfications that caused to	ne death. Do no								Approximate Interval Between
ш	Physician		Immediate Cause (Final disease or condition	Hear	the his	Tiere							Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence o	f):							
	Examiner	L	Sequentially list conditions,	b	thosis								montes
	be slt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence o	r):							
	be executed sician and burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as a	consequence o	f):							
8760,	Attending Physicien: The law requires that the death certificate be executed rideath. rideath. ector: After this certificate has been signed by the attending physician and bette time tuneral director, page 2 should be detached for use as the burial-transit.	lcal E		d									
9	ificate g phys as the	edic											
Вох	eath certific attending p I for use as I	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, nutcome of 1 Live birth 2		3∏Ecton	c pregnancy					ate of deliv	
о. В	s deal he att ed for	sicie	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at ti 9☐Unknown		5 🗌 Othe					, n	Month	Day Year
<u>Р</u>	at the de d by the a etached i	Phy	9 Unknown			Alban considerated		- in Book		23a Did to		ntributa to t	the cause of death?
Š,	ires that signed t d be det		Part If. Other significant conditions of	ontributing to death but	not resulting in	trie underlyi	ig cause give	enin Pani.			s 2 No	3 ☐ Pro	./
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Rec	has ge 2 a	шрl								autops	V	prior to co death?	opsy findings available ompletion of cause of
	icien: Th certificate rector, pag		25. Was case referred to medical					OC Place	of Coath	perform	/~	1 🗌 Yes	2 No
5	ysicien: The is certificate hadirector, page	To Be	examiner?	Hospital: 1 ☐ Inpatien	2 ER/Out	patient 3	DOA Othe	ar V		_(<i>Check only on</i> ne 5 ☐ Reside		ther (Speci	fv)
10	g Phy er thi		27. Manner of Death	28a. Date of Injury (Month, Day			28c. Injury Work	4		28d. Describe ho			,,,
0	Attending Ph er death. ector: After th by the funeral	atio	1 Natural 5 Pending 2 Accident investigation		1021)	М		Yes 2 □ N	lo				
Division of Vital	er de	Certification:	3 Suicide 6 Could not be 4 Homicide determined		y - At home, far (Specify)	m, street, fa	tory, office		2	28f. Location (St City or Town		nber or Rur	al Route Number,
	ital o urs affi ral Di								ļ				
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edicai	29a. Certifier Check only 2 Medical Exen	ysician: To the best of niner: On the basis of e	xamination and	, death occu Vor investiga	red at the tim tion, in my o	ne, date and pinion, death	place, a	and due to the ca ed at the time, d	ause(s) and r ate and place	nanner as s , and due t	stated. to the cause(s)
	thin 2	Mec	29b. Signature and title of certifier	and manner state			29c. License	e number		2	9d. Date sign	ed (Month,	Day, Year)
)	F ≯ F 8		MASI	TIME			1	12.59	57		-	1.06	
			30. Name and address of person who	completed cause of de	ath (Item 23a) (Type, Print)	,		1	. ^	3		
			M.D. Crowley,	10 610	Dutcher	mens L	ane,	1-1259	(we	MD	21601	7	
- 1	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	han	Nº E						
	Regist	ar	OHN T 9 5	UUU SEE	that So	P. Carlo	Self. Self						

			For State Registrar	State of M	-	epartment o		ind Menta	l Hygien Reg. No	~ UU (012	218
	Physici: /Medic		1. Decedent's Name (First, Middle, I Helen Louise Ha					Mor	of Death oth Da	ay Year	3. Time of D	eath M
	Examin		4a. Facility Name (If not institution, g Frederick Memori	ive street and number)		4b. City, Tow Frede	n, or Location o		40	c. County of Dear		
	Funeral Director				ge (In yrs. last birth 89 Yı	Months Da		Min. (Mor	of Birth oth, Day, Year 7 1916	5 Fre	chplace (State or Fountry) derick Caryland	-
	hours after deeth with the Maryland turel', or Items 23s or 28e-1 show al Examinar must be nutilised at	ector	10a. State 10b. County MD Freder	ick	10c. City, Town	wick					10d. Inside City 1 X Yes 2	
	in 72 hours after deeth with the Marylan 1°neturel', or lleme 23s or 28e-1 ehow Indicel Examinar must be nutitled at	Funeral Director	10e. Street and Number 1201 Maple Terra	12. Was Decedent	Ever in U.S.	10f. Zip Cod 217	16	gin? (Specify Yes		itizen of What Co USA 14. Race - Ame	nican Indian,	
9000	nours after urel', or ite	ğ	1 ☐ Never Married 2 ☐ Married 3 📆 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	No	1 □ Yes 2 🔀	No Specify:	, Puerto Rican, e		Specify:	Thite	
Maryland 21215-0036	within 72 liene. r than "ne tre Medic	Completed	15. Decedent's (Specify only highest of Specify only highest of Specify only highest of Specify (0-12)	Grade completed) College (1-4or	5+)	Decedent's Usual Oc Give kind of work do life. DO NOT use re fterial W	ne during most tired)	of working		Kind of Business Inswick I School	Elementa	ry
yland	should be filed vind Mental Hygie marked other tumatic event, III	To Be C	17. Father's Name (First, Middle, La Martin VanRay Ma	ain, Sr.			Dais	r's Name (First, I y Wand (Gosnell	-		
	27 le		19a. Informant's Name/Relationship Richard L. Harr		n 85	Mailing Address (Str Pennsylv	ania La	ne, Berl	keley S	Springs,	WV 2541	1
Baltimore,			20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		cemetery,	Disposition (Name o., crematory or other eights Ce	metery		Bru	ocation - City or		
Ball	permit. Page Depertment of Important: If eny Injury or			illiams, Ov	Mer		ersvill	e Road,	Brunsw	ne vick, MD	21716	
,	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Me	Sentence of	ie it.	faret	un	atory arrest,		Interval Betwee	
8760,	death certificate be executed be ettending physicien and inder use as the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Dua to (or as	a consequence of):						
P.O. Box 68	death certif e ettending od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregna 5 □ Other (specify			_	23d. Date of del Month	ivery Day Ye	ar
	The lew requires that the site has been signed by the bage 2 should be deteched.	<u>م</u>	Part II. Other significant conditions	contributing to death I	but not resulting in t	the underlying cause	given in Part I.	236			o the cause of dear	
al Records,		Completed						1 🗆	was an autopsy performed?	prior to death?	utopsy findings av completion of cau 2 No	allable ise of
f Vital	Physiclan: This certifice ral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2	Hospital: 1 Inpati	ent 2 ER/Outp	Salletti 3 DOA	Other: 4 Nu	of Death (Check rsing Home 5		6 □Other (Spe	cify)	
Division of	of a strending Phefore death. I Director: After the in by the funeral	Certification:	27. Manner of Death Matural 5 Pending 2 Accident investigal 3 Suicide 6 Could no 4 Pending determing	be 28e. Place of In	ay Year) Inj		injury at Work? 1 Yes 2 1	No 28f. Loc		nd Number or Ri	ural Route Numbe	97,
Ö	i gig c		4 Hollicide	building, e Physician: To the best	tc. (Specify)				to the cause(s		stated	
	To the Hospitel within 24 hours e To the Funerel I completely filled	Medical	(Check only /2 ☐ Medical Ex	aminer: On the basis of and manner s	of examination and	or investigation, in r	ny opinion, deat	th occurred at the	e time, date ar	nd place, and due	to the cause(s)	
	or con	-	29b. Signature and title of certifier	men		296. 00	ense number 4716	9		ate signed (Mont		
	10		30. Name and address of person wh	to, mo	6109	ype, Print) I, th AVE	- BRU	Menic	KIM	166	6	
	Sta Registi		31. Date filed (Month, Day, Year) JAN 0	9 2006	rar's Signature	Societies	1					

		State of Maryland / Department of Health and M 1- State State OF Death Certificate of Death		-21	006	01219
		1. Decedent's Name (First, Middle, Last)	2. Date of Dea			3. Time of Death
Physici	_	ROSA CATHERINE DONIVER HOWARD	Month Januar	v 03	. 2006	7:50A M
/Medio Examin	Olical Ab City Town and parties of Day			1	ounty of Deat	
LXaiiiii		Civista Medical Center La Plata		C	har1es	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		9. Birtl	nplace (State or Foreign
Director		212-32-7064	8. Date of Birth (Month, Day JUNE 4,	1928	MĂĬ	YLAND
pu 🛾		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		-		10d. Inside City Limits
larylan show	7	MARYLAND CHARLES INDIAN HEAD				1 □XYes 2 □ No
or 28a-f	ect	10e. Street and Number 10f. Zip Code		IOo Citiza	n of What Co	
be tiled within 72 hours after deeth with the Maryland be tiled within 72 hours after deeth with the Maryland Hygiene. A shown of other than "natural", or items 23a or 28a-f show event, the Madical Exaction must be notilised at	Funeral Director	#85 WOODLAND DRIVE / P.O. BOX 42 20640		_	ED STA	
ms 2:	era	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14	. Race - Ame	
after dee or itams	Ē	Armed Forces? If Yes, specify Cuban, Mexican, Puerto 1 □ Never Married 2 □ Married I □ Yes 2 ₺ No Specify:	Hican, etc.)		Black, White	etc.
ours Frail,	d by	3 M Widowed 4 Divorced Year or Dates:		3,	pecify: BL	ACK
72 hours natural',	ete	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	ing	16b. Kind	of Business/I	ndustry
within me.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		ном	E MAKI	NG
iled v Hygie ther t		9TH GRADE HOME MAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name	(First Middle			
e d fa) Be	JOHN DAVID DONIVER RUTH ADE	•			
should Me	은	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	al Route Number	r, City or T	own, State, Z	ip Code)
# 2 = 5		TREASA DONIVER CARTER / DAUGHTER 1305 FARMINGTON ROAD EA	AST, ACC	OKEE	K, MAR	YLAND 20607
ges 1 and 2 t of Health If Item 27 or other tre		cometon, cromaton or other place)	Date	20c. Loca	tion - City or 1	Fown, State
Pages nent of int: If Its		1	9, 2006	GLYM	ONT, M	ARYLAND
permit. Page Department of Important: If any Injury or		21. Signature of Fune & Service Censes 22. Name and Address of Facility THE WITH FUNE HOME, P 3439 LIVINGSION ROAD, IN	A IDIAN HEAT) MAR	YLAND 2	0640
TK E TO		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.			11110 2	Approximate Interval Between
Dhyeician		Immediate Cause (Final				Onset and Death
Physician disease or condition resulting in death) Due to (or as a consequence of):						
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cuted nd ransi	Examiner	cause Enter Underlying Cause (Disease or injury that initiated events c. A ordoniz Stomach				
te be executed ysician and burial-transit		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
9 9 5 5	edical	d. Will Eff the Mill of the				
		IF FEMALE:				
eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?		230	 Date of delivers Month 	very Day Year
The law requires that the death certified has been signed by the attending bage 2 should be detached for use a	Physician/M	1 Yes 2 No 9 Unknown Unknown The past 2 The past 3 Other (specify) Other (specify) Other (specify) Other (specify) Other (specify) Other (specify) Other (specify) Other (specify) Other (specify) Other (specify) Other (specify) Other (specify) Other (specify) Other (specify) Other (specify) Other (specify) Other (specify) Other (specify) Other (specify				,
that the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	pacco use	contribute to	the cause of death?
signed I	d by		1 🗆 Ye	s 2 DH	√0 3 □ Pro	bably 4 Unknown
w require been si should b	etec		240 14500	- I,	74h Mara aut	anny findings available
has l	Completed		24a. Was a autops perforr	y .	prior to co death?	opsy findings available ompletion of cause of
ician: The certificate ha			1 Yes	No No	1 Yes	2 No
sician: certific rector,	Be	25. Was case referred to medical examiner? 10 Your 20 No. Hospital: 4 Separate 20 FR/Outpations 20 Post Other: 4 No. 1 No. 2			70	
Physic ratidis	1. 10	To the state of th	ne 5∐ Reside 28d. Describe ho			(fy)
ding Ith.	tlon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No		1- 7		
Attan dea ctor by the	flca	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office			Vumber or Rui	ral Route Number,
al or a after t Dire	Certification;	4 ☐ Homicide building, etc. (Specify)	City or Towr	i, State)		
To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, f	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.				
Fo the vithin 2 Fo the complet	Me	29b. Signature and title of certifier 29c. License number	2	9d. Date s	igned (Month	, Day, Year)
F > F 0		D-0057999		Ì	30	6.
		30. Name and addr ss of person who completed cause of death (Item 23a) (Type, Print)			1	
DB		Manisha J. Jariwala,MD 11637 Terrace Drive Ste. 103	Waldorf.	Marv	land 2	0602
Sta	_	31. Date filed (Month, Day, Year) 32. Redistrar's Signature		, J		
Registr	ar	JAN 0 5 2006 Marie & Sparke				

Elizabeth Hertzler 06 - 01221 - For State Registrar AKG

Physician

/Medical

Examiner

Funeral

1. Decedent's Name (First, Middle, Last)

St. Mary's Hospital

5. Social Security Number

Usual Residence of Decedent

N/A

Maryland

10e. Street and Number

10a, State

Directo

Elizabeth Maria Hertzler

4a. Facility Name (If not institution, give street and number)

10b. County

St. Mary's

1□M 2AF

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygier

Months 9

4b. City, Town, or Location of Death

Leonardtown

Mechanicsville

10f. Zip Code

State	O.	Maryland /	Department	OI I	icailii a
			Certificate	of	Death

Yrs.

10c. City, Town or Location

7. Age (In yrs. last birthday)

ne.	0	.79	yee	~	ě	~	0	
A STATE OF THE STA	U		h			7	2	

Year

5, 2006

3. Time of Death

1:48 P

2. Date of Death

Januarv

Month

	Directo
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 ie marked other then "naturel", or iteme 23a or 28a-f show eny injury or other traumatic event, it a Medical Examinar must be notified at one.

/Medical

Examiner

physicien and s the burial-transit

esn

the Hospitel or Attending Physicien: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

20659 37377 Locks Crossing Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 n N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benuel R. Hertzler Ida M. Hostelter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37377 Locks Crossing Rd. Mechanicsville, MD 20659 Benuel R. Hertzler / Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Hertzler Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signatore of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. Truchael Kevan Hardine P.O. Box 270, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PROBABLE BRONCHO PNEUMONIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 24a. Was an 2. No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 25 EP/Outpatient 3☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) XXYes 2 □ No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

4c. County of Death St. Mary's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) March 31, 2005 Maryland 10d. Inside City Limits 1 ☐ Yes X☐ No 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry N/A 20c. Location - City or Town, State Jan. 7, 2006 Mechanicsville, MD Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physicians To the bast of my knowledge death occurred at the time date and place, and dire to the naisu(s) and making as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) January 6, 2006 111 Penn Street, Baltimore, Maryland 21201

Registrar

after deeth.
I Director: Aff

29/x Catilier

(Check only one)

29b. Signature and title of certifier

AWA

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RUB101

Y1ar 0 2006

MD

32. egistrar's Signature

within 24 hours a To the Funerel C

Medical

29c. License number

O.C.M.E.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2006 8:35P. January 2, Clarence Ray Hartlein /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours 1 XM 2 □ F Months Pennsylvania 165-09-6090 86 Yrs. Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Introducer if item 27 is marked other than "naturel", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be seen any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Silver Spring **Funeral Director** 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 12801 Old Columbia Pike, #202 20904 United States 12. Was Decedent Ever in U,S.
Arrived Forces?
1 [ZhYes 2 □ No
If Yes, Give
Year or Detes: WWII. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married Married Baltimore, Maryland 21215-0020 1 ☐ Yes 🎾 No Specify: White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seventh Day Adventist 18. Mother's Name (First, Middle, Maiden Surname) Clara Simmendinger 17. Father's Neme (First, Middle, Last) Raymond Jacob Hartlein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ella May Hartlein -wife 12801 Old Columbia Pike,#202 Silver Spring, Md20904 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State George Washington Cemetery 1/8/2006 Adelphi, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 mal 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner by Physician/Medical Examiner CHRONIC signed by the attending physicien and d be detached for use as the buriel-transit Hospital or Attanding Physician: The law requires that the death cartificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760. RRHOSIS Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ARTERY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Medicai Certification: To this within 24 hours after death.

To the Funeral Director: After this complately filled in by the funeral (27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ş 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 JANUARY 4, 2006 un 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) TAKOMA PARK, MARYLAND 20912 LOUIS LARCA MD 7901 MAPLE RUENUE 31. Date filed (Month, Day, Year) State JAN 05 2008 Registrar

KOMMA PER HOMT TIT 06-00257 Unpend item # Za, 27, Za-f, pen/E, 353,3/2//06 IT State of Maryland / Department of Health and Mental Hygiene RKD Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Ronny Lee Hunt, III JANUARY 2006 12:45P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death **ELKTON** CECIL UNION HOSPITAL If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 4, 2005 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days Hours 1 MM 2 □ F 219-73-1491 Maryland Director 6 Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State th and Mental Hygiene. 7 is marked other then "naturel", or frems 23a or 28a-f show traumstic event. The Medical Examiner must be mutified at 1 ☐ Yes 21 No Directo Maryland Ceci1 E1kton 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 10 Rock Creek Drive 21921 United States Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ☐ Yes 2 No Yes, Give 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Not Applicable Not Applicable 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Shauna McGough Ronny L. Hunt, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i Brenda L. Hunt/Grandmother 24 Rock Creek Drive, Elkton, Maryland 21921 20b. Place of Disposition (Name of Commetery, crematory or other place)
Gilpin Manor
Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
important: if ite
eny injury or ott January 13, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 Elkton, Maryland Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sudden unexplained death in infancy /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examine or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of). physician a Box 68760. Physician/Medical as for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ icate has been signated page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a. Was an autopsy this certificate Yes 2 No director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 __fnpatient 2 XER/Outpatient 3 __ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 X Yes 2 □ No After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No unk death. investigation 2 Accident unk the Director: d in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide after within 24 hours aft To the Funeral Di complately filled in unk To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29c License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies

State Registrar

MRON 31. Date filed (Month, Day, Year) JAN 1 8

2006

32. Registrar's Signature

se of death (Item 23a) (Type, Print)

O.C.M.E.

JANUARY 11, 2006

		_	State of Maryland / Department State of Maryland / S	artment of Health and M rtificate of Death		ene 2006	01223
	Dhusisi		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Meta 0.	Howlett	January 3,		10:10 P M
	Examin	er	4a. Facility Name (If not institution, give street and number) Waldorf Healthcare	4b. City, Town, or Location of Death Waldorf		4c. County of Deal Charles	h
	Funeral Director		5. Social Security Number 6. Sex 1 M 2KT 7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	9. Birl (Co 27.1918 Vir	hplace (State or Foreign ountry)
	σ		Usual Residence of Decedent		December	2/ • 1/10 VII	
	arylar ehow	_	10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits 1 Yes 2 XNo
	the M	Director	Maryland Prince Georges Fort Wash	11 II g COII	10.	g. Citizen of What Co	
	With	ī	12902 Chalfont Avenue	20744		USA	
	ms 23	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, I've Medical Evantral relative multiped at 2008.	by Fur	1 Never Married 2 Married 1 ☐ Yes 2 🔯 No	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🏿 No Specify:	Rican, etc.)	Specify: Whit	
Š	2 hou	ted	15. Decedent's Education 16a. Dece	dent's Usual Occupation	11	6b. Kind of Business	Industry
215	thin 7 e. en "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of worki DO NOT use retired)		Fodom-1 C	
2	ygien ygien her th	Con		nasing Agent 18. Mother's Name		Federal Go	overnment
Maryland 21215-0036	uld be fii /ental H rked otl tic ever	To Be	17. Father's Name (First, Middle, Last) Homer S. Orebaugh	Opa1	Bernic		ier
lary	2 short and his ma		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rura	al Route Number,	City or Town, State, 2	Zip Code)
	and lealth m 27 her tr			Chalfont Ave., Ft		gton, MD 2	
Ore	ges 1 It of H if ite or of		1 ☐ Burial 2 ☑ Sremation 3 ☐ Removal from State	natory or other place)			
Baltimore,	it. Pa intmer intent: injury		'4 □ Donation 5 □ Other (Specify) Kalas Crem 21. Signatur Juneral Service 22	Name and Address of English		Edgewater, 1	
Ba	Department of the partment of		> /flage P. Cales	5160 Oxon Hill Road Oxo	on Hill, Ma		0745
В			23a. Part 1 Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
Л	Pnysician		Immediate Cause (Final disease or condition resulting in death)	nent,a			tears.
	/Medical Examiner		Due to (or as a consequence of):				
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	uted d ansit	Examiner	Cause. Chief Underlying Cause (Disease or injury that initiated events				
oʻ	e exectan an	Exa	resulting in death) Last Due to (or as a consequence of):			į.	
8760,	death certificate be executed e attending physician and od for use as the burlal-transit	dical	d				
9	eath certific attending p for use as	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			22d Date of dal	*
Вох	atten for u	Physician/Me	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of del Month	Day Year
o.	that the de led by the a detached f	hysi	1 Yes 202No 9 Unknown				
ري. ص	The law requires that the ate has been signed by the bage 2 should be detache	by PI	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	icco use contribute to	the cause of death?
ord	w require been sig should b	ted	anemia		1 Tes	2 □ No 3 □ Pr	obably 4 🖫 Unknown
Records,	e law n has be je 2 sh	Completed			24a. Was an autopsy	prior to	topsy findings available completion of cause of
E E		Con			performe 1 ☐ Yes 2	ed? death? No 1 ☐ Yes	2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death			
of		1: To	27. Manner of Death 28a. Date of Injury 28b. Time of	It 3 DOA Nursing Hor	me 5 ☐ Residen 28d. Describe how	ce 6 □Other (Spectron) of injury occurred	cify)
on	Attending r death. actor: After by the fune	atlor	1 ☑totatural 5 ☐ Pending (Month, Ďaý Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			1
Division	or Attendi after death. Director: A in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
J	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edicai Ce	29a. Certifier (Check only (Check only 2 Medical Examiner: On the basis of examination and/or in				
	ro the vithin 2 ro the complet	Med	one) and manner stated. 29b. Signature and tale of certifier.	290 License number	290	d. Date signed (Monta	h, Day, Year)
)			+ AMAY S	U27308		January 4, 20	006
L	(17)		30. Name and address of person who completed cause of death (Item 23a) (Type, +CWAN TRIPE TO 100, 12C	Print) ON Ine Con	r MAID	mf Mi	20602
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 4 2006		· JVV)	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** January 1, Daniel Fmi 1 Innamorato 2006 8:18 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Y August 22, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign 6. Sex . 1918 **Funeral** 1√XM 2□ F 87 Pennsylvania 579-09-2736 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at Oxon Hill Maryland Prince George's 1 ☐ Yes ZXX No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1813 Brierfield Road 20745 USA "natural", or Items 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 XXYes 2 □ No If Yes, Give 1 Never Married 2 XXMarried Baltimore, Maryland 21215-0036 WI 1 Yes 2000 Specify: White β 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) 1 year Inspector Foreman Federal Government other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked ony injury or other traumatic ev Antonia Martino Vito Angelo Innamorato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9500 Morsten Lane Gaithersburg, Maryland 20886 Daniel A. Innamorato / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 1/4/2006 Kalas Crematory Edgewater, Maryland 5 Other (Specify) * 4 ☐ Donation 21. Signatu e Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE Physician /Medical Due to (or as a consequence of): **Examiner** ATHEROSCLEROTIC MEART DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician. Records, P.O. Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No be detached signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Tenknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 Yes 22 No 2□ No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNX 2 2XXER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 XXX ural 5 Pending after death. | Diractor: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospitel of within 24 hours at To the Funaral D t⊈ XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific D050545 January 3, 2006 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Godswill O. Okoji MD 7513 New Hampshire Avenue Takoma Park, Maryland 20912 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

ADH Amend 23a, perME 0872 101/6/07 TT

Unpend item#23a, 27 perME 0852, 2/8/06 TT

State of Maryland / Department of Health and Mental Hygiene
State of Maryland / Department of Death

For Amend Item#5 per INF 6851 1/30/06 UC PAUL JOHNSON 06 - 0276For Amend Item#5 per INF G851
Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 0914 11, Ам Pau1 Johnson William JANUARY 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE WASHINGTON MEDICAL CENTER GLEN BURNIE ANNE ARUNDEL 8. Date of Birth (Month, Day, Year)
July 12,1967 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 2615-91×19835 **Funeral** Months Days Hours Min 1**X** M 2□ F Yrs. California Director 38 216-84-6680 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylar Department of Heelih end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be trauffled at 005a. 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1544 Star Stella Drive 21113 USA Funeral 12. Was Decedent Ever in U.S. Amed Forces? 12. Wes 2 □ No If Yes, Give Year or Dates: 1987-89 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2XXVo Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Law Enforcement Police Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Russell Johnson Lucille Ledeux 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen S. Johnson (Wife) 1544 Star Stella Drive, Odenton, MD 21113 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition MXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Our Lady of the Fields 1-14-2006 Millersville, MD 21. Signature of Funeral Services 22. Name and Address of Facility
Hardesty Funeral Home, P.A. đ 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. In the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Cardianegally associated with amyloidosis and hypertrophic changes disease or condition

a.

The first change is a specific or respiratory arrest, and hypertrophic changes are or condition. Approximate Interval Betweer Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal deal
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 5 Other (specify) be detached 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2√ No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete 1 Se Yes 2 □ No 1 Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 XYes 2 □ No Certification: To

or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records, funeral director, After To the Hospital or Attendent within 24 hours effer death.
To the Funeral Director: Aft completely filled in by the fur.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 5 Pending м 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mather as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one)

29c. License number

OCI4E

29d. Date signed (Month, Day, Year)

JANAURY 12, 2006

State Registrar

Medical

Z Groenberg Tasha 31. Date filed (Month, Day, Year) JAN 1 7 2006

29b. Signature and title of certifier

111 PENN STREET, BALTIMORE, MARYLAND, 21201 MID 32 Registrar's Signature

dip

200

2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			1- For State of Maryland / Department of Heat State of Maryland / Department of Heat Certificate of Department of Department of Heat State of Maryland / Department / Departme	46-	giene 006 01226
	Physici /Medic Examin	al]	1. Decedent's Name (First, Middle, Last) Vernetta, Marie Johnson	2. Date of Dea Month A / C	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If	Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day	9. Birthplace (State or Foreign Country)
	the Maryland 28a-f ahow office at	ector	10a. State 10b. County 10c. City, Town or Location Salisburg 10e. Street and Number 10f. Zip Code		10d. Inside City Limits 1 Yes 2 □ No 10g. Citizen of What Country?
	23a or	Funeral Director	911 North Division St 21801		21.5.A
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural" or Items 23a or 28a-f ahow other traumatic event, the Wedical Exdin actional be notified at	þ	If Yes, Give 1 ☐ Yes 2 ☐ No S Year or Dates:	anic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.) Specify:	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	filed within 72 h Hygiene. other than "natu ant, the redica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+)	ng most of working	16b. Kind of Business/Industry Cold Water Scafaed
Maryland	should be filed nd Mental Hygid markad other umatic evant, the	To Be (17. Father's Name (First, Middle, Last)	Mother's Name (First, Middle,	Maiden Sumame) Vu tter
	1 and 2 sho Health and 16m 27 Is my othar traum		George Tuhnson - SON P.O. BUX 13	Manticoke	Md 21840
altimore,	g = t		20a. Method of Disposition 1.28Burial 2 Cremation 3 Removal from State 1.4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place)	1/7/06	20c. Location - City or Town, State
Balti	permit. Pag Department Importent: I any injury o			of Facility Bennie 3	south Turent Have
	Priysician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	uch as cardiac or respiratory are	rest, Approximate Interval Between Onset and Death
	/Medical Examiner		a	C 4 -	
	ed .	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	TO E TWO	
8760,	ate be executed hysician and the burial-transit	dical Examiner	resulting in death) Last Due to (or as a consequence of):		
O. Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown		23d. Date of delivery Month Day Year
ords, P.	w requires that been signed b should be dela	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given if	n Part I. 23e. Did to	obacco use contribute to the cause of death? 'es 2 No 3 Probably 4 Unknown
Vital Records,		e Completed	or was a second		prior to completion of cause of death?
of Vil	shys this	ToB	examiner? 1 Yes 2 No	3. Place of Death (Check only or 4 Nursing Home 5 Hesid	lence 6 Other (Specify)
	Jing After fune	atlon	27. Manner of Death 1 Hatural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 1 Yes	28d. Describe h	now injury occurred
Division	o Dire	Certification;	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined building, etc. (Specify)	28f. Location (S City or Tow	Street and Number or Rural Route Number, vn, State)
	To the Hospitel or within 24 hours after To the Funaral Dir completely filled in I	Medical C		date and place, and due to the con, death occurred at the time, c	cause(s) and manner as stated. date and place, and due to the cause(s)
	To t with	Σ	29b. Signature and title of Sinfier DO O		29d. Date signed (Month, Day, Year) しくりんのも
-	a a		30. Name and address of person to completed cause of death (Item 23a) (Type, Print) TA COCKEY, NO 1746 S. N: VIJIV	n 18, Sali	Jonny Mdz1804
	Sta Registi		31. Date filed (Month, Day, Tear)		//

VALERIE	JONES
06-00086	,
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(4	2)

State of Maryland / Department of Health and Mental Hygiene

ible.	(e)	
06	01228	

			- State Registrar Amended item #2 per wichd/	Certificate of Death 01-06-2006 Addas
			1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 3. Time of Death
	Physicia		Vallie L	Jones January 3, 200\$6 8:30 p. M
}	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
	Exami	٠.	3421 W. Caton Avenue	Baltimore Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi	irthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Director		218-16-5100 10M 2XF 83	Yrs. Months Days Hours Min. (Month, Day, Year) Gountry)
			Usual Residence of Decedent	The first state of the state of
	/lanc		10a. State 10b. County 10c. City, Tow	wn or Location 10d. Inside City Limits
	Mar.	ţ	Marile 1 Br. Himmer Ba	Himore 17 Yes 2 No
	288 100	Je C	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	With Sa	Funeral Director	3421 1/ Cal Dung	21229 454
	eath	era	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Specify Yes or No-
	ter d	ä	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.
98	rs ef	by	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify: Specify: Specify:
21215-0036	72 hours efter death with the Maryland Insture!, or iteme 23a or 28a-f ehow disal Exantinet must be notified at	ed		a. Decedent's Usual Occupation 16b. Kind of Business/Industry
5	in 72	Completed	(Specify only highest grade completed)	(Give kind of work done during most of working life. DO NOT use retired)
7	within ene. then "	Ē	Elementary/Secondary (0-12) College (1-4or 5+)	Nursing Asst. Nursing Home
	filled Hygi sther		17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumarie)
an	ld be ental ked c	Be c	James Henry Finne	Lillia Paul Co
2	d Me mark	ဥ		b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Maryland	ges 1 end 2 should be filed within 72 hours efter death with the Marylar it of Health and Mental Hyglene. If Item 27 is marked other then "nature!, or iteme 23s or 28s-f show or other treumatic event, it a Medical Examinar must be notified at		Earl L. Finney. Brother 6	210 Papers Street Gilstowy Marilial 21861
-	1 en Heal Pm 2 ther			of Disposition (Name of Date 20c. Location - City or Town, State
ğ	Peges nent of int: if it		1 Burial 2 Cremation 3 Removal from State	ery, crematory or other place)
計				donia Biptist 1-8-2006 bloxen, Virginia
Baltimore	permit. Pege Department of Importent: If eny Injury or		21. Signature of Fun ral Service Licens 4	22. Name and Address of Facility 917 W. Fsubella Steeet
	40 F • a	/	unt for	Bennie Smith Funeral Home Salistany Med 21801
П			23a. Part1. Enter the disease, erce/mplications that caused the death. Do shock, or heart failure. List only one cause on each line.	Interval Between
1	Physician		Immediate Cause (Final disease or condition	Cardiovascula Discusp. Onset and Death
	/Medical		resulting in death) Due to (or as a consequence	
П	Examiner		Sequentially list conditions, b	
	₽ ≒	ner	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying) of):
	ocute ind trans	Examiner	Cause (Disease or injury that initiated events c.	
ő	e exe		resulting in death) Last Due to (or as a consequence	3 of):
68760	certificate be executed iding physiclen and ise as the burial-transit	/Medical	d	
	ing p	Med	IF FEMALE:	
× ×			23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	th 3 Ectopic pregnancy
Ö.	dea ed fo	Sici	1 Yes 2 No 4 Pregnant at time of death	5 Other (specify) Month Day Year
P.0	The lew requires that the death tie hes been signed by the etter bage 2 should be detached for t	Physicia	9 Unknown	
	res the	þ	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
of Vital Records,	w require been si should I			1 Yes 2 No 3 Probably 4 Unknown
S	law re as be	ojet		24a. Was an 24b. Were autopsy findings available
æ	The I	Completed		autopsy prior to completion of cause of performed?
tal	@ L	O	25. Was case referred to medical	1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one)
5	Physician: this certific ral director.	0	examiner? ¹ XYes 2 □ No Hospital: 1 □ Inpatient 2 □ ER/O	Other
	Physical c	-	100000	Time of Injury at Work? 28d. Describe how injury occurred
Division	Attending r death. Sctor: After by the fune	ţ	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury Work? M 1 □ Yes 2 □ No
isi	or Attendation of Attendation description of the crossistic of the	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home.	
ā	를 를 들	Certification;	4 Homicide determined building, etc. (Specify)	City or Town, State)
	Hospital or 24 hours afte Funeral Dit tely filled in		2ian Cartifier 1_1 Certifying Phynician: To the best of my knowledge	ge, don't occurred at the time, date and place, and due to the cause(s) and manner as statud.
	To the Hose within 24 ho To the Fune completely f	Medical	(Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.	and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
	, nn)	I DOLLARY IN	OCME January 4, 2006
	W.		30. Name an address of person who complet a suse of death (Item 23a	
	100		5 R. HOGAN	Jan Solder Barelinoit, Intryland 21201
3	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	A
	Regist		JAN 0 6 2006 Mague Jr.	. Sparte
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			For State Registrar	caoc	State	of Ma		d / De		nt of H	lealth a	and M	lental Hy		005	01230	
153	Physici /Medic Examin	al er	Decedent's Name (First, M W I L L I A M 4a. Facility Name (If not institute)	HAI	R I S O N	ımber)	OHNS	SON			r Location (2. Date of De Month JAN.	1 O	2006 County of Dea	3. Time of Death 00:21 a M]
	Funeral Director		SOUTH MARYLAN 5. Social Security Number 230-14-5757	6. 5		7. Age		last birthd Yrs	ay) If Unc	Pr 1 Year Days		24 Hrs. Min.	8. Date of Bi (Month, Di JUNE 12	1		FEORGE 'S thplace (State or Foreign Duntry) HMOND	7
	Ba-f show		Usual Residence of Deceder 10a. State 10b. Co MARYLAND					y, Town o	RE							10d, Inside City Limits	
	ath with the 23e or 24	rai Dire	10e. Street and Number 5 0 0 7 GWYNN	OAK					2 3	ip Code 217				$U \cdot S$	·		
900	within 72 hours after death with the Maryland ene. then "neturel", or liems 23e or 28e-f ehow the Madical Examiner must be notilied at	by Funeral	11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 □ Divo		12. Was Dec Armed F 1 [XYes If Yes, G Year or I	orces? 2 □ N ive		.S. 1	If Yes, sp	edent of H ecify Cuba 2 X No	lispanic Ori an, Mexicar Specify:	n, Puerto	ecify Yes or No Rican, etc.)		14. Race - Am Black, Whi Specify: BI	te, etc.	
21215-0036	I within 72 ho liene. r then "natur the Medical	Completed	15. Dec (Specify only h Elementary/Secondary (0- 8	ighest gr	ducation ade completed College		+)	(G	cedent's Usive kind of the DO NOT	rork done i use retired	durina mos	t of work	ing		COMP	·	
Maryland 2	uld be filed Mental Hyg irked otheric event.	e e	17. Father's Name (First, Mic ADOLPHUS SE										e (First, Middle JOHN		Sumame)		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; or items 23a or 28a-1 show any njury or other traumatic event, the Madical Examinat must be notified at ance.		19a. Informant's Name/Rela MATTIE JOHN 20a. Method of Disposition 12 Burial 2 □ Crema	SON (WIFE)	State	, c	500 Place of Disemetery,	7 GW	NN (OAK Z	AVEN	IUE BAI Date	20c. Lo	cation - City or	21217	
Baltimore,	permit. Pag Department Important: any njury once.		4 Oonation 5 Oth 21. Signature of Funeral Se			N	MUI	di-		and Addre	ss of Facili	by BE	RRY O.	WAD	DΥ	GINIA 225	05
(88760,	ifficate be executed g physician and as the burial-transit	dicai Examiner	23a. Part1. Enter the diseas shock, or heart ailure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	List only	a. Due to	each lin	TIPL a conseq a conseq	uence of):	STI	10K	25				LSHE	Approximate Interval Between Onset and Death	5
P.O. Box 6	death cer e attendin id for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	t		birth Inant at	of pregna 2 Feta time of d	death	3 □Ectopic 5 □ Other (′				23d. Date of de Month	livery Day Year	
	w requires that the been signed by th should be detache	þ	Part II. Other significant co	ditions 17E	contributing to	death bu	ut not res	ulting in th	e underlying	cause giv	en in Part I			tobacco u Yes 2[the cause of death?	
of Vital Records,	The law ate has b page 2 s	Completed	2)2932	541	UDRO.	48	29						24a. Was auto perfi 1 \(\text{Yes}		prior to death?	utopsy findings available completion of cause of 2 No	,
Vit	S 0 T	To Be	25. Was case referred to me examiner? 1 ☐ Yes 2 ☑No	dical	Hospital:	Únpatie	nt 2 🗆	ER/Outpa	itient 3	OOA Oth	or		h <i>(Check only</i> me 5 □ Res		3 □Other (Spe	ocify)	
Division of	ding After fune	Certification: 7	2 Accident in	ending vestigation	28a. Date (Mo	of Injui	ry V Year)	28b. Tim Inju	e of ry M	28c. Injur Wor 1 🗀		No	28d. Describe	how injur	y occurred		
Divi	To the Hospital or Attention 24 hours after deatly the Funeral Director: completely filled in by the		4 ☐ Homicide d	etermined	286. Plac	ding, etc	c. (Specil	(y)	street, fact		re, date a		City or To	wn, State)	ural Route Number,	
	the Ho nin 24 h the Fu	Medical	(Check only 2 Me one)	ical Exa	miner: On the and ma	basis of	examina	ition and/o	r investigati	on, in my o	pinion, dea	ith occurr	red at the time,	, date and	place, and du	e to the cause(s)	
	Wit To Conf		29b. Signature and title of c	rtmer					7	9c. Licens		15	-		e signed (Mon UAAY		5
	5		30. Name and address of pe	rson who	completed car	12	070	0,	pe, Print)	LIK	18 0	EDV	ER U	UAC	DOUF.	10, 2000 Ud. 200	02
	Sta Regist		31. Date filed (Month Day	2008	32.	Registra	ar's eigna	atura									

			For	State of Maryla	nd / Depa		aith and N	•	•	
			= State Registrar		Ce	rtificate of De	eath		leg. No.	10 01231
Ph	nysicia	ın	1. Decedent's Name (First, Middle, La	•				2. Date of Dea Month	Day	3. Time of Death
1	Medic	al .	Elmer Asbury Joy 4a. Fecility Name (If not institution, giv			4b. City, Town, or Loc	cation of Death	January	10, 20	006 7:07 P M
4 E	xamin	er	Avalon Manor Nurs			Hagerstow			Washir	
Fur	neral		5. Social Security Number 6. 5	Sex 7. Age (In yrs	. last birthday)	If Under 1 Year If	Under 24 Hrs.	8. Date of Birth (Month, Day		Birthplace (State or Foreign Country)
Dire	ector		218-16-2656	¹\\ M 2□ F	OO Yrs.	Worters Days	TOUTS WITH.	May 02,	1905	MD
and	,	1	Usuel Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
Mary	fled	ţŏ	MD Allegar	ny Ti	ttle O	cleans				1 ☐ Yes 2 🗖 No
th the	fora	by Funeral Director	10e. Street and Number	19 131	CCIC O	10f. Zip Code		1	10g. Citizen of W	'hat Country?
ath wi	d and	rai	31716 Old Adams H	Road, NE		21766		1	USA	
ar deg	E E	nue	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	J.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black	- American Indian, k, White, etc.
rs aff	TE S	by F	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	1 Yes 2 M No If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No S	Specify:		Specify:	
IIIU Z I Z I 3-0030 be filed within 72 hours after death with the Maryland H bygiene.	ical	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupation	n		16b. Kind of Bus	White siness/Industry
thin 7	Med	Completed	(Specify only highest gri Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done during DO NOT use retired)	ng most of work	ing		
buld be filed with Mental Hygiene.	킾	ပိ	17. Fotbodo Nomo (First Middle / co.	2)	Auto	Mechanic	Mark - d - N			ve Repair
d be fi	909	Be	17. Father's Name (First, Middle, Last Arley Joy	,			Cora Mi		Maiden Sumame	1)
2 should I	mati	٦	19a. Informant's Name/Relationship	Type, Print)	19b. Maili	ng Address (Street and			r. Citv or Town. S	State. Zip Code)
1 and 2 Health a	other traumatic event, the Medical Examiner must be notified at		Geraldine Wheeler	c/Daughter		5 Green Lan			MD 21742	
es 1 and of Health	te l		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐		Place of Dispo cemetery, cre-	osition (Name of matory or other place)		Date	20c. Location - 0	City or Town, State
permit. Pages Department of P	Jury		`4 Donation 5 ☐ Other (Speci	(y) Pi		ains U.M.	01/13	3/06 L	ittle Or	leans,MD
permit. Departr	any in		21. Signature of Funeral Service Lice	200		2. Name and Address of				ain Street
- 401		-	23a. Part1. Enter the disease, or con	poligations that caused the dea						21750-0368 Approximate
Dhusi	isian		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.						Interval Between Onset and Death
Physi /Med	dical		disease or condition resulting in death)	Due to (or as a conse	quence of):	Ca-do Evas	laray	dise	ase	(6)
Exam	niner		Sequentially list conditions	p Dewe	en Alia					1 C X
p	Sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of).					
xecute	-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):					
e be e)	buria	calE		S.d.	,,-					
tificate	as the			. 0.						
th cert	r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet		Ectopic pregnancy				of delivery
e dea	of ber	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of 9 Unknown		Other (specify)			Mon	th Day Year
hat th	detacl	Phy	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause given in	n Part I	23e. Did to	bacco use contri	bute to the cause of death?
OI U.S., requires	ld be	d by		•	g		.,			3 Probably 4 ⊠Unknown
	shou	Completed						24a. Was a	n 24b. W	/ere autopsy findings available
The la	age	omp						autops perfori	sy pr med? de	rior to completion of cause of eath?
VII.di ician:	ctor, p	BeC	25. Was case referred to medical examiner?			26	S. Place of Deat	h (Check only or	7	2000
Physic	aldire	ဥ	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2					ence 6 Othe	
tending Fleath.	funera	lon:	27. Manner of Death 1 ☐ Hatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work?	2 🗆 No	28d. Describe ho	ow injury occurre	d
Attending r death.	y the	fica	2 Accident investigation 3 Suicide 6 Could not to 4 Demonstrate determined	28e. Place of Injury - At I	home, farm, st		20.00	28f. Location (Si	treet and Numbe	r or Rural Route Number,
al or /	d in	Certification:	4 Homicide	building, etc. (Spec	eify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death.	aly fills	edical (29a. Certifier 1 Certifying P	hysician: To the best of my kr miner: On the basis of examin	nowledge, deat	h occurred at the time, o	date and place,	and due to the c	ause(s) and man	iner as stated.
the hin 24	прівіє	Medi	one)	and manner stated.		29c. License nu				
N T	3 8	_	29b. Signature and title of certifier				535	1	/ ///	(Month, Day, Year)
~			30. Name and address of person who	completed cause of death (Its	om 23a) (Tvne		0 0 0 2	,	' (''/&	1
0			Farid Murshed, N	4.D. 1126 Opal	Court	Hagerstown	, MD 21	740		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	w				
- н	legistr	al 💮	JAN Z II /UU	U REPORT STATE	1-1					Į.

			For State Registrar	State	of Maryla		artment of F rtificate of i		nd Mer		iene og. No.	(12	32
ı	Dhysiai		1. Decedent's Name (First, Middle, La	st)	-				2.	Date of Deat Month		ear	3. Time of	Death
	Physicia /Medic		DAVINIA ANN	JAMES					JA	ANUARY			12:05	A M
	Examin	er	4a. Facility Name (If not institution, given 7635 MARSHALL)	4b. City, Town, o POMF I		Death		4c. County of CHAR		;	
Т	Funeral			Sex		s. last birthday)	If Under 1 Year Months Days	If Under 24		Date of Birth (Month, Day,	Year) 9	Birthpl	ace (State o	or Foreign
ļ,	Director		3/3-40-3413	1□M 2⊠F	73	Yrs.					5,1932			VANIA
	fand ow		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ecation					10	d. Inside C	ity Limits
	Mary F-f sh	to	MARYLAND CHAP	RLES		POMF	ЗЕТ						1 🗌 Yes	2 ∑ No
	th the or 28s	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen of Wha	t Count	ry?	
	death with the Maryland ms 23a or 28a-f show		7635 MARSHALL	CORNE			206				U.S	. A .		
30	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "naturel", or litems 23a or 28a-1 show event, the Madical Examiner out the nollited at	by Funeral	11. Marital Status 1 □ Never Married 2∑Xarried 3 □ Widowed 4 □ Divorced	Armed F	Ž \ Ž\Vo ive		Was Decedent of H If Yes, specify Cuba 1 □ Yes ※XXNo	ispanic Origir an, Mexican, I Specify:	n? (Specify Puerto Ric	y Yes or No- an, etc.)	14. Race - Black, 1 Specify:	White, e		
9500-612	2 hour		15. Decedent's E	ducation		16a, Dece	dent's Usual Occup	ation			16b. Kind of Busin			
ر د	hin 72	Completed	(Specify only highest gr	ade completed,	1-4or 5+)	(Give	kind of work done DO NOT use retired	durina most o	of working				,	
7	ifiled with Hygiene other the	Con	12			НОМ	EMAKER				OWN	HOM	E	
yland	and Mental Hygi and Mental Hygi is marked other eumatic event,	Be	17. Father's Name (First, Middle, Las							First, Middle, N	Maiden Sumame)			
	should ind Men ind marke umatic	P	LUKE WARREN	VANDE(GRIFT	405 14-10	- 141 (01	VIRG		ADA				
Ma	d 2 sl th an t7 is r treur		19a. Informant's Name/Relationship RAY E. JAMES-F		D	187	ng Address <i>(Street</i> MARSHAI				•			675
ē,	ss 1 and 2 should of Health and Men item 27 is marker other treumatic		20a. Method of Disposition				sition (Name of matory or other place		Date		20c. Location - Cit			
altimore,	Pages ent of nt: If i		1 ⊠Burial 2 □ Cremation 3 € 1 □ Donation 5 □ Other (Special Control of the Contr		JIAIO		matory or other piac ETERANS	1	01-1	3-06	CHELTEN	НΔМ	I. MD	
a	permit. Pages Department of I Importent: If ite any injury or o'		21. Signature of Funeral Service Lice	nsee	M0047	9 - 2	2. Name and Addre	ss of Facility					7 110	
מ	99 = 9		marka (20.5	5		RAYMOND La Plat i					•		
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that one cause on	caused the de each line.	ath. Do not end	er the mode of dyin	g, such as ca	ardiac or re	espiratory arre	est, 1		Approximat Interval Bet Onset and	ween
	Pnysician / /Medical	H	Immediate Cause (Final disease or condition resulting in death)	a	R	nal	failu	e					Orisot and	Dodin
	Examiner			Due to	(or as a conse	equence of):	-0 VW	011:1						
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conse	equence of):		un!	VIS			-		
1	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
Š,	e exe sian a urial-1	Ex	resulting in death) Last	Due to	(or as a conse	equence of):								
09/8	icate be executed physician and s the burial-transit	dical	•	d										
×			IF FEMALE:	23c. If yes, or	utcome of preg	nancy					23d. Date of	f deliver	7/	
Box	The law requires that the death certif ite has been signed by the attending page 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live 4□Preg	birth 2□Fe nant at time of	tal death 3	Ectopic pregnancy Other (specify)	1			Month		-	Year
J.	res that the de signed by the a be detached f	hys	9 🗆 Unknown	9□ Unkr	nown									
	es the	by F	Part II. Other significant conditions	contributing to	death but not re	esulting in the u	nderlying cause gıv	en in Part I.	- 4		pacco use contribu			
ecords,	w require been si should b	ted							-	1 🗆 Ye	s 2□No 3[_ Proba	ibly 4 📵	Jaknown
Hec	e law has b le 2 sl	Completed								24a. Was a autops perforr	y prio	r to corr	sy findings	available ause of
			05.14					-		1 ☐ Yes 2	2 10 No 1 🗆	Yes	2 D No	
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ot Ot	g Phy er this	H	27. Manner of Death	28a. Date		28b. Time o					ow injury occurred	Specify,	/	
201	anding Fath. or: After he funer	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	on	nin, Day 16ar)	Injury		Yes 2 □ No	0					
Division	el or Atto	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	4 200. Plac	e of Injury - At ding, etc. (Spec	home, farm, st cify)	reet, factory, office		28f.	Location (St City or Town	reet and Number on, State)	or Rural	Route Num	iber,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certificacompletely filled in by the funeral director.	Medical (29a. Certifier 1 Certifying P (Check only one) 1 Medical Exe	miner: On the	e best of my k basis of exami nner stated.	nowledge, deat nation and/or in	h occurred at the tirvestigation, in my o	ne, date and pinion, death	place, and occurred	d due to the ca at the time, d	ause(s) and manna ate and place, and	er as sta I due to	ated. the cause(s	5)
	To the To the comp	Σ	29b. Signature and title of certifier				29c. Licens	e number		2	9d. Date signed (A		Day, Year)	
			,				D-45	737			1/8/01	,		
	6		30. Name and address of person who					1117777	01.5					
	Sta	ate	NIRMALADEVI JAYAN 31. Date filed (Month, Day, Year)	NITAN, MI	ノ 11345 Registrar's Sig	Manue LEMBRO	OUKE SQ. S	SULTE1(04 WA	LDORF,	MD_20603			
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	D	10e. Street and Nu	ook Valle	y Road		1	Of. Zip Code 21701			_	Citizen of What (Country?
	by Funeral	11. Marital Status	ried 2⊠ Married	12. Was Decedent Armed Forces 1 Yes 2 Yes If Yes, Give Year or Dates:	?		Decedent of s. specify Cu	f Hispanic Origin? (uban, Mexican, Pue lo Specify:	Specify Yes or I into Rican, etc.)		14. Race - An Black, Wh	nerican Indian, hite, etc. Thite
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	To B	Michae	1 E. Ko	opper, Sr.	_			Susan	L. H	o11a	nder	
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		Susan L. 20a. Method of Dis	Kopper/I	Mother	20b. Plac	26/3 Bt ce of Disposition netery, cremato	OOK V	alley Roa	d, Fred	7.	k, Mary	land 21701
			Cremation 3 [5 Other (Speci	☐Removal from State				eme. 01/1	1/2006			ing,Maryla
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** ESTHER MITMAN KACHLINE JANUARY 14, 2006 11: 45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST VINCENT de PAUL NURSING CENTER FROSTBURG ALLEGANY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 8-15-1904 Birthplace (State or Foreign Country)
 PENNSYLVANIA Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 212-38-7367 1 ☐ M 2 🔀 F 101 Director Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "natural", or items 23s or 28s-f show treumatic event, it a Medical Examinar must be notified at Director 1 XYes 2 No MD ALLEGANY FROSTBURG 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 103 FROST AVENUE 21532 U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. WHITE 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify 3 ☐ Widowed 4 M Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 TEACHER COUNTY SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GEORGE W. MITMAN ANNIE HESS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a importent: if item 27 is any injury or other treu MARGARET BRIDGES 12511 woodcock Hollow ROAD MT SAVAGE MD 21545 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State CUMBERLAND CREMATORY 1-16-06 CUMBERLAND MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
SOWERS FUNERAL, P.A. 60 W. MAIN STREET M Sowers MO0547 140 FROSTBURG, MD 21532 HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LBNGESTIL disease or condition resulting in death) Many years /Medical Due to (or as a consequence of): Examiner Consclerates Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the attending physician and the for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No cate has been signated to page 2 should to 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 2 12 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manper of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 5 Pending 1 Yes 2 No investigation 2 Accident Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) 30. Name and address of person who completed suse of death (Item 23a) (Type, Print) FROSTBURG Hary Sand 21532 DATURALINA CHANGMI) 34. Registrar's Signature 31. Date filed (Month, Day, Year) State 0010 8 Registrar JAN 2 0 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 25 27 28a-f per meo 9851 1-13-06 vt.

State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan. 1, 2006 Yeer **Physician** 11:50 A M Linda Margaret Lusby /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LaPlata, MD Civista Medical Center Charles If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. | 25, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F 1948 North Carolina 265-90-9306 57 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or Itams 23a or 28a-1 show traumatic event, the Medical Exact her must be notified at 1 ☐ Yes 2 No Director Maryland Calvert St. Leonard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1570 Overlook Drive 20685 United States Completed by Funeral filad within 72 hours aftar daath 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiana. Elementary/Secondary (0-12) Coilege (1-4or 5+) Office Administrator Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) parmit. Pagas 1 and 2 should be a Department of Haalih and Mantal Important: if item 27 is months injury or other 2006. Be Albert Ripley Marion DeWalt 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1570 Overlook Drive, St. Leonard, Maryland 20685 ace of Disposition (Name of Date 20c. Location - City or Town, State Gary W. Lusby (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metropolitan Crematory 1/3/2006 Alexandria, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 4405 Broomes Island Road, Port Republic, Maryland 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final KROBANSLY **Physician** NYMONARY MASSAL CMBOLW disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner T996T WI. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed CERTIFICATION APPROVED BY MEDICAL EXAMINER use as the burial-tran the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy The law requires that the death in the past 12 months?

1 Yes 25 No
9 Unknown jo Month Year Day 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown signad by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cartificata has autopsy 2 X No 1 Yes Physician: tha funaral diractor. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: Yes X No Certification: To 1 Inpatient 2X ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Aftar 5 Pending investigation or Attanding Accident 6:00 p M 12-15-05 subject fell after daath i Diractor: daath 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 1570 Overlook Drive Saint Leonard, Maryland fillad in by 4 Homicide home within 24 hours a To tha Funarai C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) complataly (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20

State Registrar

3 2006 JAN 1 DHMH 17 Rev 1/2001

TEORENE

31. Date filed (Month, Day, Year)

M()

NAIDORF.

20603

ne and address of person who completed cause of death (Item 23a) (Type, Print)

32

ATHEN

pegistrar's Signature

					S	tate of	Mar	yland /	•	ırtment <i>tificate</i>				nental Hy	/giene Reg. No. 0	06	0.1	237
	Physicia		1. Decedent's Nem	ne (First, Middle	i, Last) Ingri	id E.	Law	vs						2. Date of D Month	eeth Dey	Yeer 2000	/ /	ime of Death
	/Medic Examin		4a Fecility Neme ((If not institution							4	lb. City, To	own, or L	ocation of Dee	th 4c. Cour	nty of Dea	th	
			Genesis H							W I Feder	1 Vaar		aton	T		rtgom		
	Funeral Director		5. Social Security N 125 14 43	346	6. Sex 1 ☐ M			In yrs. lest 30	Yrs.	If Under Months	Days	Hours	Min.	8. Date of B (Month, D June 2	, 1925	9. Bir Ne	thplace (sountry) W YO:	State or Foreig
,	land		Usuel Residence of 10a. Stete	10b. County			10	0c. City, To	own or Lo	cation							10d. Ins	ide City Limit
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	or 28	je j	10e. Street end Nu				,			10f. Zip					10g. Citizen o		-	
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36	ges 1 end 2 should be filed within 72 hours efter death with the Maryland to f Heath end Mentel Hygiene. If Item 27 is marked other than "natural", or items 23a or 28e-f show or other traumatic event, the Medical Examinar must be notified at	by Funerai Director	11. Marital Status 1 ☐ Never Mari 3 文Widowed	ried 2 Marri	ied 1	Vas Deced Armed Ford □ Yes 2 f Yes, Give Year or Del	ces? 2.[2K]No	er in U,S.		Yas Decede Yes, speci		Ispanic Oi in, Mexica Specify		pecify Yes or N Rican, etc.)	Spec	lace - Ame lack, Whit		ian,
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Maryland	2 should end Men Is marke		19a. Informant's N	_		Print)				_					ber, City or Tow			
	1 end 2 Health em 27 l		Janet Jew		er					Pinde sition (Nam		Schoo	ol Ro		ton, M			-4-
Baltimore,	permit. Peges 1 end Depertment of Health Important: If Item 27 any Injury or other ti DRCs.		4 Donation	Cremation 5 ☐ Other (Sp	oecify)	val from S	tate	ceme	ntery, crem O Cre	natory or other emator	her plac Y		1	Date -2006	20c. Locatio	vill	e, M)
Bal	permit Depen Import any In		21. Signature of Fi	uneral Service I	Licensee	W	M. M	40104	4 22 41	. Name and	.d. C	ss of Fecil Olumi	Harı Jia I	cy H. W Pike El	itzke's licott	Fam City	ily 1 , MD	TH Inc. 21043
			23a. Pert1. Enter t shock, or hea	the disease, or art failure. List	complication	ons that ca	used the	e death. D	o not ente	er the mode	of dyin	g, such a	s cardiac	or respiratory	arrest,		Appro	oximate al Between t and Death
	Physician /Medical		Immediate Cause	(Final		/	5	ch	060	ع ،	15	1/:	AC	•				
Н	Examiner		disease or condition resulting in deeth)		θ	() ر Du	e to (or es			((//	1. 7				<u> </u>	
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Records,	aw requires that the death certific is been signed by the ettending F 2 should be deteched for use es	Completed by												24a. Wa	s an autopsy ormed?		available	opsy findings prior to on of cause
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no	dlng F h. After funer	tion	1 Natural 2 Accident	5 Pendin- investig	g	8e. Date of (Month	, Dey Y		Injury	M	Worl	k? Yes 2⊡] No	280. Describe	now injury occ	Julied		
Division	l or Attending Physician: efter deeth. Director: After this certific d in by the funeral director,	ertifica	3 Suicide 4 Homicide	6 Could r	not be	Be. Plece of building	of Injury g, etc. (- At home Specify)	, farm, stre	et, factory,	office				(Street and Number) State)	mber or R	ural Rout	e Number,
	To the Hospital or Attending Physician: The I within 24 hours effer deeth. To the Funeral Director: After this certificete ht completely filled in by the funeral director, page	Medical Certification:	29a. Certifier (Check only one)	1X Certifying	Examiner:	n: To the b On the bes	sis of ex	aminetion	ige, deeth and/or inv	occurred a restigation,	t the tin	ne, date a pinion, de	nd place, ath occur	and due to the red et the time	cause(s) and , date and plac	manner a e, and du	s stated. e to the ca	ause(s)
	Vithi Vithi Comp	Σ	29b. Signature and	d title of certifier	A	then	Dir	4/11	Mys	290.	Licens	e number)53	642	Jan	ned (Mon	20	06
(2)	102		30. Name and add	ress of person	who comple	eted cause	of deal	(Item 23	e) (Type, I	Print) R	av	la	BI	VD 3	203 &	Bali	tim	50212
	Sta		31. Date filed (Mor	Jan a	e 200	. 43		Signature	60	d								
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ORIGINAL

Amend Item 1 per Dr., G853, 03/15/06dhb Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Month Year Physician Covey 10:00AM MANI LO VEY 2006 8, January /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Caroline Ruxton Health of Denton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) **Funeral** Months 1□M **X**□.F Yrs. Director 216-40-3633 96 Nov.20,1909 Maryland Usuel Residence of Decedent Pagas 1 and 2 should be filed within 72 hours after deeth with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Denton 1 Yes 2 No Caroline Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? United States 21629 420 Colonial Drive Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ▼ No Specify: White δ 3 Widowed 4 □ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Interior Design Consultant Interior Design 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mantel h Nettie Trice Curtis Edward Williamson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Doris Harding/Daughter 129 Bloomingdale Ave., Federalsburg, item 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MDHillcrest Cemetery 1/15/06 Federalsburg, 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical myocardial marchin < I how Examiner Due to (or es a consequence of) Examine Attending Physician: The lew requires that the death certificate be executed burial-trensit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760, Physician/Medical the Due to (or as a consequence of): P.0. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown HTW Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? Drmenha TLIYES 2 No 1 ☐ Yes 2 ☐ No certificete Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 □ Yes 2 □ No 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director; A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) within 24 hours aftar d To the Funeral Direct completely filled in by it 4 Homicide ò edicai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R.R. Drais MD 01/09 D0061688 06 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) RUPAL R. DESMI 2108 DiDonaho Powe Chustu MD 2-16/9 31. Date filed (Month, Day, Year) 32. Registrer's Signature State

Registrar

		4	For State Registrar	State of	Marylan		artment of F				iene	06	012	39
			Decedent's Name (First, Middle	, Last)		-			2.	Date of Deat	h		3. Time of E	Death
	sicia edic	_	Donna	Kay	Lor	ng			Ja	Month Inuary	Day 2	200 6	1418	М
	ımine		4a. Facility Name (If not institution	, give street and numb	oer)		4b. City, Town, o	r Location				ty of Death	1 2,20	
1			6303 White Cove	Drive			Salisl	oury			Wico	mico		
Fune	eral		5. Social Security Number	6. Sex 7.	Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Min.	Date of Birth	Year)	9. Birthp	lace (State or	Foreign
Direc	tor	-	219–60–2007	1 □ M 2 2 F	52	Yrs.			8	Month, Day 10/19	53′	Mary		
and w	95	-	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					1	0d. Inside City	Limits
faryla •ho		5	,	omico		Salis							1 X Yes :	
the N		Director	10e. Street and Number	J200			10f. Zip Code			10	0g. Citizen of	What Cour	ntn/2	
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Jeath The 20		Funerai	11. Marital Status	12. Was Deced	ent Ever in U	.S. 13.			igin? (Specif	v Yes or No-		ice - Americ	an Indian.	
the second		ᆵ	1 Never Married 2 X Marr		X No	1	Was Decedent of H If Yes, specify Cuba			án, etc.)		ack, White,		
ours a		ğ	3 Widowed 4 Divorced	If Yes, Give Year or Date			1 □ Yes 2 X No	Specify:	:		Spec	ity: WN	ite	
1215-0036 within 72 hours after death with the Maryland one. than 'natural', or Items 23e or 28e-f show		Completed	15. Decedent (Specify only highes	's Education		16a. Dece	dent's Usual Occup	ation	st of working		16b. Kind of I	Business/Ind	dustry	
	E E	ᇍ	Elementary/Secondary (0-12)	College (1-4	lor 5+)	life.	DO NOT use retired	d)						
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Man 12 st hang rien		- 1	19a. Informant's Name/Relations John Andrews/b				ng Address (Street 760 Old F							
		1	20a. Method of Disposition		20b. P		sition (Name of		Date	-	20c. Location			
Baltimore, bermit. Peges 1 ar Depertment of Hee mportant: if Item:	5	3	1 ☑ Burial 2 ☐ Cremation		ate C	emetery, crei	natory or other plac					27444.0		
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Dhuniai			shock, or heart failure. List Immediate Cause (Final	only one cause on each	th line.	, ,							Onset and De	
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		ē	Sequentially list conditions,	b. Due to (ur	as a conseq	uanca of).						-		
uted	10	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
O, exec en an	Ġ	Ш	resulting in death) Last	Due to (or	as a conseq	uence of):								
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OX 68 OX 68 or certification of the second o	2		IF FEMALE:	1							_		5	
Box (eath certif ettending		an/	23b. Was decedent pregnant	23c. If yes, outco	me of pregna h 2 □ Feta		Ectopic pregnancy	,				ate of delive	,	
D. B. e death he ette		SICI	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of d		Other (specify)				M	lonth	Day Ye	ar
, P.O. that the de detached	2	Physician/Me	9 Unknown											
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Cord: w require been sig		Completed								1 □ Ye	s 2 No	3 P100	abiy 4 □Un	IKNOWN
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On ding	3	텵	1 □Natural 5 □ Pendin	g (Month,	Day Year)	Injury	Wor	k? Yes 2(∑		the sale	ch r	_		
VISION Attending r death. ector: After		lica	3 ☐ Suicide 6 ☐ Could r	not be 200 Place of		FOLKU 14	eet, factory, office			Location (Str	eet and Num	ber or Rura	l Route Numbe	e/
Division of Vital Records, of or Attending Physician: The law requires to elfer death. Director: After this certificate hes been signed in by the funeral director page 2 should have		Certification:	4 Homicide determ	building	, etc. (Specify	At 1	10mm -			City or Town,	. State)			
Division of the Hospital or Attending Phymitin 24 hours effer death. To the Eureral Director: Affect hindral complately filled in by the funeral incomplately filled in by the funeral			29a. Certifier 1 ☐ Certifyin	g Physician: To the b	est of my kno	wledge, deat	occurred at the tin	ne, date an	nd place, and	due to the ca	use(s) and m	nanner as st	ated.	MU
ne Ho 7 24 } in Fu		Medical	(Check only XX Madical one)	Examiner: On the bas and manne	is of examina	tion and/or in	vestigation, in my o	pinion, dea	ath occurred	at the time, da	te and place	, and due to	the cause(s)	
To th To th		ž	29b. Signature and title of certifier				29c. Licens	e number		29	d. Date sign	ed (Month, I	Day, Year)	
100	3		(ab 700	1057	19		OC	ME		J	anuary	7, 3,	2006	
160	2		30. Name and address of person	who completed cause	of death (Item	n 23a) (Type,	Print)							
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Reg	gistra	ır	0 MAL.	6 2006	last an	12 6	mark in							

		State of Maryland / Depart Statement State of Maryland / Depart 1- Statement State of Maryland / Depart Statement State of Maryland / Depart Statement State of Maryland / Depart Statement Stat	artment of Health and Mental Hygiene	2006 01240
		Decedent's Name (First, Middle, Last)	2. Date of Death Month Da	y Year 3. Time of Death
	sician edical	Totaloon Tourido Toor		, 2006 3:15 p M
	miner	A DE MAN AND AND AND AND AND AND AND AND AND A	4b. City, Town, or Location of Death 4c	. County of Death
		Calvert Memorial Hospital		Calvert
Funer		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year)	
Direct	or	Usual Residence of Decedent	July 31, 1	951 Missouri
land		10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
Mary fsh	j	MD Calvert North	Beach	1 ☐ Yes 2 ☑ No
the 28a	Director	10e. Street and Number		tizen of What Country?
n with	0	9335 Chicago Avenue	20714	USA
deatl	Jers	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian,
after or its	by Funeral	1 □ Never Married 2 □ Married 1 □ Types 2 □ No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:	Black, White, etc.
A I A I D-UUSO Not within 72 hours aff giene. or then "natural", or the Medical Exami	P P	3 ☐ Widowed 4 NDivorced Year or Dates: 1979–85	103 2A NO Specify.	Specify: white
72 t 27	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	kind of work done during most of working	(ind of Business/Industry
Paritin A	2	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) edical technician me	dical equipment
CLE 15-UUSD filed within 72 hours after death with the Maryland Hygiene. Wher then "natural", or Iteme 23a or 28a-f show nit, the Medical Examiner must be retified an	ပိ		18. Mother's Name (First, Middle, Maider	
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IOTE, MATYIANG ZIZIS-UUSO ges 1 and 2 should be filed within 72 hours after death with the Marylan tt of Health and Mental Hygiene. It litems Z1 is marked other than "naturat", or iteme 23a or 28a-1 show or other fraumatic event, the Medical Examin erroration or other traumatic event, the Medical Examin errorations.	Ę		ng Address (Street and Number or Rural Route Number, City	
and 2 and 2	2 /	Barbara A. Tassa, sister 9335	Chicago Ave., North Beach,	MD 20714
s 1 and 2 f Health item 27		20a. Method of Disposition 20b. Place of Dispo		ocation - City or Town, State
Page Page Nent of nt: M		1 🗆 Buriai 2 💢 Cremation 3 🗀 Hemoval from State		exandria, VA
Baltimore, permit. Pages 1 a Department of Hea important: If item	á	The state of the s	2. Name and Address of Facility	, , , , , , , , , , , , , , , , , , ,
n 88 E 8	Buce	William K Crow	Rausch Funeral Home, P.A., C	wings, MD 20736
		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respiratory arrest,	Approximate Interval Between
Physicia	an	Immediate Cause (Final disease or condition MP+05+0+ic P00	rly differenciated Non-	Cmall 3 la Roks
/Medic Examin		Dao 10 (01 as a solisoquolise 01):		
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be tist	Fxaminer	if any, leading to immediate Due to (or as a consequence of):	•	
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. BOX 68/60, death certificate be executed e ettending physician and of or use as the burial-transit	dica:			
oo/	pdio	d		
EOX 60 leath certific ettending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
death death death death	-	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)	Month Day Year
	hve	9 □ Unknown 9 □ Unknown		
	34	Part II. Other significant conditions contributing to death but not resulting in the L	A :	use contribute to the cause of death?
COLC w require been si	٥	Chronic Obstructive Hirw	ay disease 1970s 2	No 3 Probably 4 Unknown
4eCC e lawr has be	9	Hypertension	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
The I	Completed		performed? 1 ☐ Yes 2 ☑ No	death?
r VITAL Properties of tractor, paged in a continuate	Re	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
Of VIta Physician: this certific		Pospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		
ing P	2 2	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 1 ☑Natural 5 ☑ Pending (Month, Day Year) Injury	Work?	ry occurred
VISION Attending r death. ector: After	40	2 Accident investigation 3 Suicide 6 Could not be 380 Place of Injury At home farm of	M 1 Yes 2 No	and Alexandra on Green Courts News how
Division of Vital Records at or Attending Physicien: The taw requires s after death. In Director: After this certificate has been sign and in hy the timeral director case 2 should be	Cortification.	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	City or Town, Stat	nd Number or Rural Route Number, e)
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in hy the it.	2		th occurred at the time, date and place, and due to the cause(e) and manner as stated
24 h	direction of	(Check only 2 Medicel Exeminer: On the basis of examination and/or in one)	investigation, in my opinion, death occurred at the time, date an	d place, and due to the cause(s)
ro th	N	29b. Signature and title of certifier		ate signed (Month, Day, Year)
->-		Gran & Surana.	D 50653	-2-2006.
		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) GVAN C. SINDANA	100000
10+1		30. Name and address of person who completed cause of death (Item 23a) (Type 5851 - Deale Church Re	pad Deale mp 20	751
100	State	31. Date filed (Month, Day, Fear) 32. Registrats Signature		
Reg	jistrai	JAN - 3 ZHUG Blown &	Sporte	

			1 - For State Registrar		aryland / Dep <i>Ce</i>	artment of F			ene 3. kg. 006	01241
	Physici	an	1. Decedent's Name (First, Middl	,				Date of Death Month	Day Year	3. Time of Death
	/Medic		HATTIE	MOORE	LOUDE	T		01-01-		3:16 p ^M
	Examin	er	4a. Facility Name (If not institution SLIGO CREEK	-		TAKOMA	TADI/		4c. County of Death MOTGOME	
	- Formula		5. Social Security Number		GPLE ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8 Date of Birth		
п	Funeral Director		239-55-5506	1□M 2€F	77 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,)	1928 LIB	place (State or Foreign intry)
			Usual Residence of Decedent					11 20	IJZU BIB	ENTA
	arylar show	<u>_</u>	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Be-f	Director		GOMERY	TAKOMA			11:-		1 XYes 2 □ No
	er death with the Marylan Items 23e or 28e-1 show	급	10e. Street and Number 7620 MAPLE	A VITE NITTE		10f. Zip Code	110	100	g. Citizen of What Cou	intry?
	eath	Funeral	11. Marital Status	12. Was Decedent	Ever in IIS 13	209		acify Voc or No-	LIBERIA 14. Race - Ameri	ican Indian
	fter d	F	1 Never Married 2 Mar	Armed Forces	No.	If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, White	
93	hours aff	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes Give		1 ☐ Yes 2X No	Specify:		Specify: B]	LACK
21215-0036	72 hours after death with the Maryland neturel', or Items 23e or 28e-1 ehow itsal Exernitrat rivalities in Millies u	Completed	15. Deceder	t's Education st grade completed)	16a. Dece	dent's Usual Occup	nation during most of work	ng 16	6b. Kind of Business/Ir	ndustry
7	within ene. than "	nple	Elementary/Secondary (0-12)	College (1-4or	life	DO NOT use retired	d)	,,9		
2	77 77 =		6th	(IOUSE WI		/F:	PRIVA	re
anc	e d ita	Be	17. Father's Name (First, Middle, THOMAS	MOORE			18. Mother's Name		aiden Sumame)	
Maryland	d 2 should by th and Menta 7 Is marked traumatic ev	P P	19a. Informant's Name/Relations		10h Mail	ng Addrage (Street	UNKNO		City or Town, State, Zi	- 0-4-1
Sa	d 2 stran		FRANKLIN LOU						PARK, MI	- '
ā,	s 1 and 1 f Health ftem 27 other tr		20a. Method of Disposition	11000	20b. Place of Disp	osition (Name of	! [C. Location · City or T	
<u>0</u>	0 0		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5			matory or other place HEAVEN			•	
Baltimore,		1	21. Signature of Funeral Service			2. Name and Addre		and the second second	LLVER SPR FUNERAL	
ä	permit. Departr Imports any inj		1/5,6	toulon			1.1		NW_WASH	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	d the death. Do not en					Approximate Interval Between
	Pnysician	0 7	Immediate Cause (Final disease or condition	Ray	201 E/	Tilun	P		1	Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequence of):	c/ (ar				
	Examiner		Sequentially list conditions	b. 154	09 hor	2 Cal	CU/US			
	Po iii	Examiner	Sequentially list conditions, many, leading to immediate cause. Enter Underlying Cause (Disease or injury	Oue to (or dr	a consequence of):	suver /	INA -	1041		
	ecute and -tran	Kam	that initiated events resulting in death) Last	c. Dur to (or as	a sequence of):	7/12 - 3	10-10	et		
8760,	ate be executed hysician and the burial-transit		,	50 to (or as	a y sequence on).		1			
687	ate hy the	Physician/Medical		d.						
Box (The law requires that the death certific tle has been signed by the attending p page 2 should be detached for use as	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of deliv	renv
ă	death a atte	iciai	in the past 12 months?	4□Pregnant a		□Ectopic pregnancy □ Other (specify) _	/		Month	Day Year
0	at the de by the tached	hys	9 Unknown	9□ Unknown						
S,	res tha igned be det	by P	Part II. Other significant conditi	ons contributing to death t	out not resolting in the t	inderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to t	the cause of death?
ğ	w require been sig should b	edt	HISTON	0 F V951	nal U	nice		1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Unknown
of Vital Records,	e law requ has been je 2 shoul	Completed						24a. Was an autopsy	24b. Were auto	opsy findings available ompletion of cause of
Ě		E O						performe	death?	No Causa di
/ita	Physicien: The this certificate ral director, pag	Be (25. Was case referred to medica examiner?				26. Place of Death	(Check only one)		/
) (hys his II dii	은	1 □ Yes 2 No	Hospital: 1 _ Inpati			A Nursing Ho		ce 6 □Other (Speci	fy)
	ling F	lon:	27. Manner of Death 1 XNatural 5 ☐ Pendi		ury 28b. Time o ly Year) Injury	Wor		28d. Describe how	injury occurred	
isi	uttendi death. ctor: A y the fu	Icat	2 Accident investi	not be One Place of le	iunz - At homo, farm, et		Yes 2 □ No	206 Location /Ctro	at and Mumber or Dur	n (Pauda Alumbar
Division	of or Attending Patter death. Director: After the in by the funera	Certification:	4 Homicide determ	building, e	jury - At home, farm, st tc. (Specify)	reet, ractory, office		City or Town,	et and Number or Run State)	ar moute number,
	pite ours interal		29a. Certifier 1 ☐ Certifying	ng Physicien: To the best	of my knowledge, deal	th occurred at the tir	me date and place	and due to the cau	se(s) and manner as	stated
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune	edical	(Check only 2 Medical one)	Exeminer: On the basis of and manner s	of examination and/or in	vestigation, in my o	pinion, death occurr	ed at the time, date	e and place, and due t	o the cause(s)
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certific	9/00-1	1 0	29c. Licens	se number	290	d. Date signed (Month,	Day, Year)
	_		1	1 total	The	DL	+547	1	1/3/0	6
1	3)		30. Name and address of person	who completed cause of	death (Item 23a) (Type	Print) C 1.	ò	00.	1 /	1
- (/		HEHEYIS	NEEV951	G.	511	40 Cr	CUIC	DUNGI	nspenne
	Sta Registi		31. Date filed (Month, Day, Year,	2006	rar's Signature	alle "				
	riegisti	C.I.	J V							

iciar		 Decedent's Name (First, Middle 	e, Last)				2.	Date of Deati			3. Time of Death
		Winnie Ale	ene Lewis					Month	Day	Year	0950
dica nine		4a. Facility Name (If not institution)	4b. City, Town, o	or Location of	Death	•	4c. County	of Death	
		Dorchester G	eneral Hospi	tal	Camb	ridge			Dor	ches	ster
al		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 2	Min	Date of Birth (Month, Day,	Year)	9. Birth	ptace (State or Foreig
r		212–12–3583	1 M 2 LA	85 Yrs.	ĺ í		F	eb. 4,	1920	Mar	yland
	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation						10d. Inside City Limit:
	.	,	chester			gate					1 ☐ Yes 2 🕱 Ño
400	Director	10e. Street and Number		.l	10f. Zip Code			10	g. Citizen of V	What Cou	into/2
ċ	5	2161 Wingate	Rishons Head	beog 5	Tot. Esp codo	21675		"	US		inity :
-	Funeral	11. Marital Status	12. Was Decedent		Was Decedent of I			v Yes or No-			can Indian,
	5	1 ☐ Never Married 2 ☐ Marri	Armed Forces? ned 1 ☐ Yes 2 🔀	No			Puerto Ric	an, etc.)		k, White	
2	•	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🕱 No	Specify:			Specify	whi	ite
	I er		t's Education		dent's Usual Occup		nd	1	6b. Kind of Bu	siness/Ir	ndustry
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	ge Re	17. Father's Name (First, Middle,	Last)						laiden Sumam	10)	
	0	Winnie Jones				Edn	a Web	b b			
1		19a. Informant's Name/Relations	thip (Type, Print)	19b. Maiti	ng Address (Street	and Number	or Rural R	oute Number,	City or Town,	State, Zi	o Code)
ı	_	Barry Lewis	so		Valley R	un, Se			19973		
	1	20a. Method of Disposition 1 Burial 2 □ Cremation	3 □ Bemoval from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce)	Date	2	Oc. Location -	City or T	own, State
		'4 □Donation 5 □Other (S		Maryland			1/9/		Hurlock		
l		21. Signature of Funeral Service	Licensee	2	2. Name and Addre	ess of Facility	Thom	as Fun	eral Ho	ome I	P.A.
		BERT			700 Locus	t St.,	Camb	ridge,	MD 21	613	
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	d the death. Do not en	ter the mode of dying	ng, such as ca	ardiac or re	spiratory arre	st,		Approximate Interval Between
		tmmediate Cause (Final disease or condition	-Ce	Otic Sto	CK						Onset and Death
ı		resulting in death)	Due to (or as	a consequence of):							
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	-	For State Registrar	State	of Mary	land / Depa <i>Cei</i>	artment rtificate					jiene eg. No.	006	01	243
Physicia	n	Decedent's Name (First, Middl	e, Last)							. Date of Dea Month	th Day	_ Year	3. Time	e of Death
/Medica	al -	Virginia Ma								Janvary	OL	1 2006	39	Ам
Examine	er	4a. Facility Name (If not institution		umber)		4b. City, T			of Death	V	40. (County of Dea		
Femanal		9 N. 5th Sti	6. Sex	7. Age (In	yrs. last birthday)	If Under 1	nton Year	If Under:	24 Hrs. 8	. Date of Birth			line	to as Foreign
Funeral Director		235-48-8252	1 ☐ M 2 💢 F	73	Yrs.		Days	Hours	Min.	(Month, Day	Year)	Co	ountry)	te or Foreign
P.		Usual Residence of Decedent								-P- 1,			C VII	ginia
arylar show det	_	10a. State 10b. County		10	c. City, Town or Lo	cation								City Limits
Ra-f	Sct	Maryland Carol	Line		Denton									es 2 □ No
a or 2		10e. Street and Number				10f. Zip (en of What Co	ountry?	
ns 23	Funeral Director	9 N. 5th Street	12. Was De	cedent Ever	in U.S. 13 ¹	Was Decede	216		nin? (Specif		U.S	• A • 4. Race • Ame	nican Indian	
r Iten	Fun	1 ☐ Never Married 2 ☐ Mar.	Armed F	orces?	10.0.	f Yes, speci	fy Cuban	, Mexican	n, Puerto Rio	fy Yes or No- can, etc.)	'	Black, Whit		,
ral', o	þ	3 XWidowed 4 □ Divorced		ive		1 ☐ Yes 2	K] No	Specify:				Specify: Wh	ite	
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vithin ne.	du	Elementary/Secondary (0-12)		(1-4 <i>o</i> r 5+)	life.	DO NOT use	retired)	27 III G 7710 St	t or working					
iled v dygie ther t		12 17. Father's Name (First, Middle,	(act)		cash	ier		10 Mothe	odo Nomo //	First, Middle, i		ery Sto	re	
d be d be santal ced o	o Be	Walter Richmor	•											
at y facility A LATE 10-0000 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. n marked other than "natural", or Items 23a or 28a-1 show umatic event. If a Modical Examinar must be nutified at	0	19a. Informant's Name/Relations			19b. Mailir	a Address				aniels		Town, State, 2	7in Code)	
nd 2 alth a 27 le	-	Emery D. Lamast	er, III,	son								land 2		
ss 1 a of Hei	-	20a. Method of Disposition			0b. Place of Dispo cemetery, crer	sition (Name	e of		Date			ation - City or		
Page nent annt: If		1 □ Burial 2 🏿 Cremation `4 □ Donation 5 □ Other (S			Chesapeak				01/09/	'06 C	hest	er, Ma	ry1an	d
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event. If a Madical Examinal must be notified at once.		21. Signature of Funeral Service	Licensee	<u>`</u>	F1 P0	Name and eegle Box	Address and 160	of Facility Helf Green	ry fenbei nsboro	in Fune	ra1	Home,	PA	
Physician		23a. Part1. Ent r the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that	caused the each line.	Myscar	er the mode	of dying	, such as	cardiac or r	espiratory arr	est,		Approxir Interval	Between ad Death
por 00, cate be executed XX physician and mine stee the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	CCIDS (or as a co	nsequence of):	c Ca	rdi	CVAS	Gulà	r Dis	eag	e	chro	nic
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w requires that been signed should be del	۵	Part II other significant conditions and the second significant conditions are second significant conditions.				nderlying car	use giver	n in Part I.				e contribute to		
s bee	piet	ALZHeim	ers DI	Seas	3					24a. Wasa		24b. Were au	topsy findin	gs available
ician: The l	e Completed	25. Was case referred to medica						00 Di	-4 D4- /6		ned? No	prior to death?	2 No	V/A
yaicie yaicie is cart diract	0	examiner? 1 Yes 2 □ No	Hospital:	Inpatient	2 ER/Outpatien	t 3 DOA	Other			Check only on		☐Other (Spe	rify)	
g Phy g Phy ler this	-	27. Manner of Death	28a. Date	of Injury onth, Day Ye	28b. Time of		c. Injury			d. Describe ho			my/	
tending leath. tor: Afte the fune	atio	1 Natural 5 Pendir 2 Accident investi	gation	mi, Day 10	ar) Injury	М		es 2□N	No					
tal or Atters all Directors of in by the	Certification:	3 Suicide 6 Could 4 Homicide determ	pined 289. Place	ce of Injury - ding, etc. (S	At home, farm, str pecify)	eet, factory,	office		28f	Location (St City or Town		Number or Ru	ral Route N	umber,
he Hospi n 24 hou he Funer pletely fill	edicai	29a. Certifier 1 ☐ Certifyir (Check only one)	ng Physician: To the Examiner: On the and ma	ne best of my basis of exa nner stated.	y knowledge, death mination and/or in	occurred at vestigation, i	t the time n my opi	, date and nion, deat	d place, and th occurred	due to the ca at the time, da	ause(s) a ate and p	and manner as place, and due	stated. to the caus	e(s)
To t To t	Σ	29b. Signature and title of certifie	and my	20	A ME	29c.	License	number	1	2	9d. Date	signed (Monti	n, Day, Year	3
	1	C. E. yeru	SUIL IIIL	rep	and IL	1	JI T	7 90			BNU	ary UG	1200	16
	1	30. Name an address of person Christian E. 31. Date filed (Month, Day, Year)	who sompleted car	use of death	(Item 23a) (Type.,	169D.	DE	NTO	M (N	D 2	167	9		
Stat	e	31. Date filed (Month, Day, Year)	32	Registrar's	Signature	All B	نا س	TAVO	/ / / //					
Registra		JAN	ZUUD A	J. Fold	1.5° 14.50	ACT CHINAS								

			State of Maryla 1 - State RegistraMFND#5perINF1/9/06, BMW, Mooo		rtment of H			ene 006	01244
	Physici		1. Decedent's Name (First, Middle, Last) TRAN LY				2. Date of Death Month	Day Yea	
	/Medic Examin		4a. Fecility Name (If not institution, give street and number) FOREST GLEN NURS/NG	HOME		Location of Death ER SPRI		4c. County of D	
	Funeral Director		5.219 S94 iv 6809 6. Sex 7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Nov. 29,		Birthplace (State or Foreign Country) Cambodia
	Maryland	tor		City, Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the	al Director	10e. Street and Number 10000 Brunswick Avenue, #308		10f. Zip Code 20910		109	g. Citizen of What USA	Country?
920	72 hours after death with the Maryland Inaturel', or Items 23a or 28a-f show Jical Ever it act mast be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 1 □ Vas 2 ☑ No If Yes, 2 ☑ No If Yes, 2 ive Year or Dates:	1	Vas Decedent of Hi Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	7	
21215-0036	within ane. than	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12	(Give I life. D	ent's Usual Occupa kind of work done d DO NOT use retired, emaker	luring most of work	ing 16	6b. Kind of Busine Or	ss/Industry wn Home
Maryland	2 should be filed and Mental Hygie is marked other reumatic event, II	To Be (17. Father's Name (First, Middle, Last) Biu Ly			18. Mother's Name Kinh Tr	e (First, Middle, Ma uc Dam	aiden Sumame)	
	Health and 2 sho Health and I tem 27 is me other treums		19a. Informant's Name/Relationship (Type, Print) Hung Van Trinh/ Husband		-			•	s, Zip Code) 20910 Spring, MD
Baltimore,	permit. Pages 1: Department of He Importent: If iten any injury or oth		₩ Burial 2 Cremation 3 Removal from State		sition (Name of latory or other place ven Cemeter	🤊 ¦ Janu	ary /	oc. Location - City	or Town, State
Balt	permit. Depart Import any inj	9 1	21. Signature on Funeral Service Licensee	50		sity Blvd	, W, Sil	ver Spri	ng, MD 20901
	Physician /Medical Examiner		Due to (or as a conse	UMOMic equence of):		g, such as cardiac o	or respiratory arres	it,	Approximate Interval Between Onset and Death Welk
,8760,	ate be executed hysician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consecutive consecution).						
P.O. Box 6	The law requires that the death certificate be executed tite has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant at time of 9 □ Unknown	tal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
	w requires that been signed t should be deta		Part II. Other significant conditions contributing to death but not re ALZHEIMER'S DISEASE	, 44	ERTES	10N,	1 🗌 Yes		to the cause of death? Probably 4 Dunknown
of Vital Records,		Completed by	HYPOTHYROIDISM, PA	RKINS	SON'S DI	SEASE,	24a. Was an autopsy performe	prior t death	autopsy findings available o completion of cause of ? es 2 \sum No
of Vita	Physicien: The l this certificate har ral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2			r. 4 Nursing Ho	n (Check only one) me 5 ☐ Residen	ce 6 □Other (S	pecify)
Division o	ding After fune	Certification:	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Special County - At building, etc. (Special County - At building, etc. (Special County - At building, etc.)			fes 2□No	28d. Describe how 28f. Location (Stre City or Town,	et and Number or	Rural Route Number,
-	To the Hospitel or Atteni within 24 hours after deatl To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my king the part of examination and manner stated.	nowledge, death nation and/or inv	occurred at the tim estigation, in my op	e, date and place, inion, death occurr	and due to the cau ed at the time, date	se(s) and manner e and place, and d	as stated. ue to the cause(s)
	Withir To th	Me	29b. Signature and title of certifier		29c. License	number	290	d. Date signed (Mo	onth, Day, Year)
	2		Chowdly, mo		04	3121		01/01/06	
			30. Name and address of person who completed cause of death (lit NURUL CHOWDHURY, MD; 9	em 23a) (Type, F 7801 GEO					
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 3 2006 32. Registrar's Sign	nature Ap	and I				

		1 - For State Registrar	State of Ma	aryland / I	Department Certificate		d Mental Hy	_ /	06 01245
		Registrar 1. Decedent's Name (First, Middle	1 2 st)		Certificate	- Or Deatri	2. Date of De	Reg. No.	3. Time of Death
Physic	ian	ARTHUR		DEN	LOVE	TACE	Month	ll Day	2006 12:25A M
/Medi		4a. Facility Name (If not institution					Jan.		ty of Death
Examir	ner				46. City, 1	own, or Location of D		4c. Coun	
		Mariner Heal 5. Social Security Number		Alr ge (In yrs. last bi	irthday) If Under	Bel Ai		th	Harford
Funeral		228-30-6029	1 ™ M 2□F	77	Yrs. Months		Min. 8. Date of Bir (Month, Da	"/1928	9. Birthplace (State or Foreign Country)
Director		Usual Residence of Decedent					1 2/13	1920	Virginia
land ow		10a. State 10b. County		10c. City, Tow	wn or Location				10d. Inside City Limits
Mary	ō	MD. Ha	rford			Jarretts	ville		1 ☐ Yes 2 No
the 288.	Director	10e. Street and Number			10f. Zip (10g. Cîtîzen o	f What Country?
ath with the Marylan 23a or 28a-f show		3620 North	Furnace	Road		21084		-	ed States
.UU36 hours after death with the Maryland tural', or tems 23a or 28a-f show al Exertiner was be multiped at	Funeral	11. Marital Status	12. Was Decedent		13. Was Decede		? (Specify Yes or No		ace - American Indian,
ter d	I.	1 ☐ Never Married 2 Marr	ied 1 ☐ Yes 2 🕅	,		ent of Hispanic Origin' fy Cuban, Mexican, P	uerto Rican, etc.)	BI	ack, White, etc.
JSD Jrs aft	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	No Specify:		Spec	"y: White
Z1Z15-UU36 d within 72 hours af giene: pr then "natural", or the Madical Exemi	ted	15. Decedent	t's Education	16a	a. Decedent's Usual	Occupation		16b. Kind of	Business/Industry
10 10 10 10 10 10 10 10 10 10 10 10 10 1	pie	(Specify only highes Elementary/Secondary (0-12)	st grade completed) College (1-4or !	E.\	(Give kind of work life. DO NOT use	k done during most of e retired)	working		
d 21215-U	Completed	4	O O	3+)	Carp	enter		Cor	struction
	BeC	17. Father's Name (First, Middle,	Last)		-	18. Mother's	Name (First, Middle	, Maiden Suma	ime)
Maryland of 2 should be file th and Mental Hy 77 is marked oth traumatic event	To B	Basil	Edgar	Love	elace	Zu	ria	Glenn	a Farmer
aryla should nd Men marke	-	19a. Informant's Name/Relations	hip (Type, Print)	198	b. Mailing Address	(Street and Number o	r Rural Route Numb	er, City or Town	n, State, Zip Code) 21084
		Sybil I. Lov	relace /Wi	fe 3	620 Nor	th Furna	ce Rd.	Jarr	ettsville, Md
altimore, I mit. Pages 1 an partment of Heali portant: If item 2 y injury or other		20a. Method of Disposition		20b. Place of	of Disposition (Nam ery, crematory or oti		Date		Of Wilson,
Pages nent of int: If it it ury or o		1. Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 Removal from State			metery 1	/14/06	Plou of.	Virginia
nit. Page artment c ortant: If injury or e.		21. Signature of Funeral Service		aw ord				~==:77.	
Department of the control of the con		m Michaela	The the	11					, Maryland
		23a. Part1. Enter the disease, or	emplications that south	d the death. De					Home, P.A.
Pnysician		shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each li	ine.	1				Approximate Interval Between
/Medical			- 12 W	21 100	14.100	dus to	Dhetr	witin	Onset and Death
		resulting in death)	a Due to (or as	a consequence	ilure	due to	Ubstr	nctiv	le short on
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Accords, P.O. Box 68 / 60, te law requires that the death certificate be executed that been signed by the attending physician and ge 2 should be detached for use as the burial-transit	by Physician/Medical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a g Unknown	a consequence a consequence of pregnancy 2 Fetal death t time of death	e of): h 3 □Ectopic pre 5 □ Other (spe	ignancy cify)	23e. Did	23d. D N Obacco use cor Yes 2 D N an 24b	ate of delivery Intribute te the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit pro-	Medical Certification: To Be Completed by Physician/Medical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown ons contributing to death be 28a. Date of Inju (Month, Da gation not be ined 28e. Place of Inju (Month, Da and manner st. 28c. Place of Inju (Month, Da and manner st. 28c. Place of Inju (Month, Da and manner st. 28c. Place of Inju (Month, Da and manner st. 28c. Place of Inju (Month, Da and manner st. 28c. Place of Inju (Month, Da and manner st. 28c. Place of Inju (Month, Da and manner st. 28c. Place of Inju (Month, Da and manner st. 28c. Place of Inju (Month, Da and manner st. 28c. Place of Inju (Month, Da and manner st. 28c. Place of Inju (Month, Da and Manner st. 28	e of pregnancy 2 Fetal death t time of death out not resulting ent 2 ER/O Iny Iny Year) 28b. jury - At home, fic. (Specify) of my knowledg of examination arated.	butpatient 3 DO Time of Injury M farm, street, factory, and/or investigation, 29c.	26. Place of Dither: 4 Nursin Work? 1 Yes 2 No office	23e. Did 1	obacco use con Yes 2 1 No an 24b psy primed? 2 1 No one) dence 6 00 how injury occu Street and Num wn, State) cause(s) and m date and place 29d. Date sign	ntribute to the cause of death? 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No ther (Specify) arred ther or Rural Route Number, nanner as stated. and due to the cause(s) ed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

			For State Registrar	State of	Marylan				ealth a Death		lental Hy	gienę Reg. No	006	012	47
			1. Decedent's Name (First, Middle, La	st)							2. Date of Dea	Day	Yea	3. Time of D	eath)
	Physicia /Medic		MARY ANN M	OORE							Januar	cy 1',	2006	12:20) PM
	Examin		4a. Facility Name (If not institution, giv	e street and nun	nber)		4b. City,	Town, or	Location of	of Death		4c. (County of De		
			FREDERICK MEMO	RIAL HOS	SPITAL		F	REDE	RICK				FREDE	RICK	
	Funeral		5. Social Security Number 6. 5		7. Age (In yrs.		If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt	h y, Year)	9. E	Sirthplace (State or a Country)	Foreign
	Director		189-32-9515	□M 2😾 F	63	Yrs.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	3.,0			July 2	2, 19	42 Pe	ennsylvan	ia
7			Usual Residence of Decedent		10a Ci	ty, Town or Lo	estica			_				10d. Inside City	Limite
IU Z I Z I D-UUSO e filed within 72 hours after deeth with the Maryland	thow Tel	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							1 -Yes 2	
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	or 28	Funeral Directo	10e. Street and Number				10f. Zij	Code				10g. Citiz	en of What	Country?	
	238	<u></u>	48 E. Moser Road				21788						ed St	ates	
900	EE	ne.	11. Marital Status	12. Was Dece Armed Fo	dent Ever in U	.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, e								
9	2 8	币	1 ☐ Never Married 2 ☐ Married	If Yes Give					Specify:			1	Specify: V	Thite	
3	4	d by	3 Widowed 4 Divorced		ates:										
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aryiand	Mental Mental arked o	ပ္	Wilmer Beveridge Ruth Vogel												
5	and Mental		19a. Informant's Name/Relationship	•	d 48 E. Moser Road, Thurmont, MD										
≥ ;			Jerry D. Moore /	Husband	lani .				au, l						
ore,	penni. Fages I am Depertment of Heal Important: If Item 2 eny Injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from	State	Place of Dispo cemetery, crea	matory or	other plac		Jan.	Date 3.	20c. Lo	cation - City	or Town, State	
Baltimor	nent ant: I		4 □ Donation 5 □ Other (Speci	(y)	Res	sthave	ı Cre	mato	ry	20		Fred	erick,	Marylan	d
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			23a Pan 1. Enter the disease, or con shock, or heart failure. List of	notications that c	aused the dee	th. Do not en	ter the mo	de of dyin	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between	een
P	hysician		Immediate Cause (Final											Onset and De	eath
	/Medical		disease or condition resulting in death)	a. Due to	or as a consec	quence of): —	7	/	7776		-			70	
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Division of	Attending Physician: r death. ector: After this certific by the funeral director,	Ica	3 ☐ Suicide 6 ☐ Could not	De Diese	of Injury - At h	nome, farm, st	reet, facto	rv. office						Rural Route Numb)er,
	Dire in by	Certification:	4 Homicide determined		ng, etc. (Spec			,,			City or To	wn, State,)		
-	To the Hospital or Attending within 24 hours after death. To the Funeral Director; A completely filled in by the to		29a. Certifier	hysician: To the	best of my kn	owledge dea	th occurre	d at the tin	ne, date ar	nd place	and due to the	cause(s)	and manner	as stated.	
	Fur Fur	edical		miner: On the b										due to the cause(s)	
	ithin o the smplk	Me	29b. Signature and title of certifier				29	c. Licens	e number			29d. Dat	e signed (M	onth, Day, Year)	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9:20 A M 1 2006 Robert Laurance Money /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ocean City

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 6/3/1921 Worcester 12346 Old Bridge Rd. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 **3**M 2 □ F 84 Yrs. Director Washington DC 579-16-2113 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State Show 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Ocean City MD Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 12346 Old Bridge Rd. 21842 death Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after tonent of Health and Mental Hygiene. Int: If item 27 is marked other than "naturel", or iter Nimed Folces: 1√Pes 2 □ No If Pes, Give Year or Dates: 1942-45 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company Cable Splicer 12 of Health and Mental Hygie fitam 27 is marked othar i r other traumatic avent, II 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) To Be Edna C. Cotton Marion J. Money 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12346 Old Bridge Rd., Ocean City, MD 21842 Theda J. Money 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition . . . • 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of important: if any injury or 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 1/3/2006 Frankford, DE 21. Signature of unera 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 ase, or complications that caused as List only one cause on each line 23a. Part1. Enter the dis shock, or heart fail. Approximate Interval Between Onset and Death e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician ML disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Steams of Injury) Due to (or as a consequence of): Examiner physician and s the burial-transit The taw requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medlcai as the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death? has 1 ☐ Yes 2 No HTX MOON 1 🗌 Yes 2 No Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. after death 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funarai I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 06 HL11828 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suice 403 Buli ND 21811 314 Brookellen iden Franklin 31. Date filed (Month, Day, Year)

JAN 0 3 istrar's Signature State 2005 Registrar

			1 - For State Registrar	State of Ma	ıryland			of H	ealth a		ental Hy		1000	0124	, 9
	Physici	an	1. Decedent's Name (First, Middle, Las Kenneth Fre		iille						2 Date of De	ath	5,200°6	3. Time of D 9:00a	
	/Medic Examin	al,	4a. Facility Name (If not institution, give				4b. City, T	Γο wn , or	Location of		Janua		County of Deatl		- 101
	Exami	iei	11528 Hanging						Sprin	ng,			Vashington		
ı	Funeral Director			9x 7. Age M∑M 2□F	85	st birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Bird Month, Da June	th y1 ^{Year}	1920 9. Birth	nplace (State or i untry) D	Foreign
	yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Localion Clear Spring,											10d. Inside City	Limits
	8a-f st	ctor		gton	CI	ear s								1 ☐ Yes 2	No No
C1212 DI	ath with the 23a or 2 ust be n	Funeral Director	10e. Street and Number 11528 Hanging	Rock Rd	•		10f. Zip	217	22			_	itizen of What Co	untry?	
	hours after death with the Maryland tural', or Items 23a or 28a-f show at Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2X Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ YN If Yes, Give Year or Dates:			. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No Specify:						14. Race - American Indian, Black, White, etc. Specify: White		
	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other than "natural", or liems 23a or 28a-1 show aumatic event. It a Medical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 3rd grade	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)					ident's Usual Occupation kind of work done during most of working DO NOT use retired) mber cutter					ndustry ood	
	uld be filed Mental Hyg arkad othe	To Be C	17. Father's Name (First, Middle, Last) Ernest Boyd Mills Sally Catherine C								er				
Mar	nd 2 sho lith and I 27 is me r traume		19a. Informant's Name/Relationship (7 Genevieve Mil										or Town, State, Z ar Spri		
baitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is markad any injury or othar traumatic es once.		20a. Method of Disposition X Burial 2 Cremation 3 C 4 Donation 5 Other (Specify		20b. Pla	ace of Dispo metery, crer irsva	esition (Nam matory or oth alley	e of her place Ce:	Jan. mete	7,2	006		ocation - City or I		D
Balt	permit. Departrimporta any inju		21. Signature of Funeral Service Licen	1, 17 '	w	Т	Name and	A D	أحد فادات	mb -	mpson	Fu	neral	Home, I	nc
ŀ	Physician		23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition							cardiac or	respiratory ar	rest,		Approximate Interval Betwee Onset and De	en eath
	/Medical Examiner		resulting in death)	Due to (or as a	a. Acute Myocardial infarct Due to (or as a consequence of): B. ASHD										
L	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	conseque	onsequence of):								12 yrs	•	
8/60,	ate be executed hysician and the burial-transit	Ical Exa	resulting in death) Last	conseque	ence of):						-				
٥	rificate ng phy as the		IF FEMALE:	u			-								
O. BOX	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnanl in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) No 9 \(\text{Unknown} \)	23d. If yes, outcome of pregnancy 1								23d. Date of delive Month	very Day Ye	ar	
cords, r.	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions co	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to											
T T	9 - 9	Completed		autopsy prior to performed? death?								prior to c death?	opsy findings avonpletion of cau	ailable ise of	
VII	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?							of Death ((Check only o				
ō	Phys this al di	lon: To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	Hospital: 1 ☐ Inpatier 28a. Date of Injury (Month, Day)		R/Outpatier 28b. Time of Injury	28	Bc. Injury Work	at ?	28	e 5 X Resid		6 ☐ Other (Spec iry occurred	fy)	
UNISION	Attaner deat	Certification:	2 Accident 3 Suicide 4 Homicide investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)				er,
	Hospital or 24 hours afte Funeral Dis stely filled in	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best o liner: On the basis of and manner stat	examination of the second of t	rledge, death on and/or in	n occurred a vestigation,	it the time	e, date and inion, deat	d place, an	nd due to the d	cause(s date an	s) and manner as d place, and due	stated. to the cause(s)	
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier				29c.	License	number			29d. Da	ate signed (Month	Day, Year)	
_	38		FB thomas	TI MD.			D	001	2237			01-	-06+06		
c	0		30. Name and address of person who of Frank B Thomas	,III,M.D		Two 1	Tonol	owa	У	Hanc	ock,	Md.	21750		
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 6 2	-33	r's Signatu	1. A.	Barle .				-				

			For State Registrar	State of M	aryland		irtment of H		d Mental Hy	giene	06	01250	
100		ř.	Decedent's Name (First, Middle, La.	st)					2. Date of Dea	ath	V	3. Time of Death	
	Physici /Medic		JOHN	EDWARD		MORGA	ΔN		JAN.	3 :	2006	0107 ^M	
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	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					IOd. Inside City Limits	
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	158 288 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Director	10e. Street and Number	1		LIDI VI	10f. Zip Code			10g. Citizen of	What Cou	ntry?	
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36	i within 72 hours atter death with the Maryland liene. I then "natural", or Items 23a or 28e-f ehow the Mudical Examuser must be rediffed at	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 📉 If Yes, Give				Specify:	ono moan, occ.)	Spec	ihe		
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yla		To	JOSEPH	MORG	GAN				SERTA		HOFF		
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nor			1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		cei	metery, cren	natory`or other plac IEAVEN CE	'	6/06			DELAWARE	
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	ding F h. Atter tunera	Certification;	27. Manne of Death 1 Natural 5 Pending	28a. Date of Inj (Month, Da	ay Year)	28b. Time of Injury	28c. Injun Worl	yat k? Yes 2∐No	28d. Describe h	low injury occu	irred		
Division	Attendi death. ctor: A y the tu	ficat	2 Accident investigatio 3 Suicide 6 Could not be determined	e 28e. Place of In	jury - At hon	ne, farm, str	eet, factory, office		28f. Location (S	Street and Num	ber or Rura	al Route Number,	
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	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: Atter this certific completely filled in by the tuneral director.	Medical (29a. Certifier Certifying PI (Check only 2 Medical Examone)	nysician: To the best miner: On the basis of and manner s	of examination	riedge, death on and/or inv	occurred at the tin restigation, in my o	ne, date and pla pinion, death o	ace, and due to the courred at the time,	cause(s) and n date and place	nanner as s , and due to	tated. o the cause(s)	
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	100		30. Name and address of person who	completed cause of	metl) diseb	23a) (Type,	Print)	() .	mn	21804			
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sici: ledic	an	Decedent's Name (First, Middle, Las				2. Date of Death Month Da	y Year	3. Time of Death				
		Nellie M. Michaux January 4 2006 6:15										
ımin	er	4a. Facility Name (If not institution, give Lorien Nursing &		4b. City, Town	n, or Location of Death	40	. County of Death					
eral		5. Social Security Number 6. Se		birthday) If Under 1 Yes		B. Date of Birth (Month, Day, Year,	Howard 9. Birtho	lace (State or Forei				
tor		511 40 0422 Usual Residence of Decedent	□ M 2 2 3 5 68	Yrs. Months Day		(Month, Day, Year, Dec. 24, 1		lace (State or Foreig htry) 1Sas				
QDC®.	_	10a. State 10b. County	10c. City, To	own or Location			1	0d. Inside City Limit				
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	급	6328 Daring Princ	o Marz	10f. Zip Code	21044		tizen of What Cour	,				
	era	11. Marital Status	12. Was Decedent Ever in U.S.		of Hispanic Origin? (Specuban, Mexican, Puerto R		nited Sta	an Indian,				
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	BeC	17. Father's Name (First, Middle, Last)		Nursing As	77	First, Middle, Maider		IOI IE				
	To B	Roy Horton			Gertrude	Brown						
		19a. Informant's Name/Relationship (7		9b. Mailing Address (Stre								
		Rochelle Michaux-										
1		20a. Method of Disposition 13℃ Burial 2 ☐ Cremation 3 ☐	como	e of Disposition (Name of etery, crematory or other p	Da	te 20c. L	ocation - City or To	wn, State				
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ı		23a. Part1. Enter the disease, or comp	Disations that caused the death. F		Columbia Pi		ct City,	MD 21043 Approximate				
		shock, or heart failure. List only o	one cause on each line.		,	1		Interval Between Onset and Death				
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į	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	ncy		23d. Date of delive Month	ny Day Year					
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	Certification; To Be Completed	examiner? 1 Yes 2X No 27. Manner of Death 1XX Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, building, etc. (Specify) Valcian: To the basis of examination	Outpatient 3 DOA D. Time of linjury M 1 farm, street, factory, office	Other: 4 Nursing Home vork? 28 Per 2 No 28	24a. Was an autopsy performed? 1 Yes 232 No Check only one 5 Residence d Describe how injuit. Location (Street a. City or Town, State	pfior to cord death? 1 Yes 6 Other (Specify ry occurred	I Route Number,				
	ertification; To Be Completed	examiner? 1 Yes 2X No 27. Manner of Death 1X Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a Certifier (Check only 2 Medical Exam	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, building, etc. (Specify) yisician: T. The hest of my knowled inner: On the basis of examination and manner stated.	Outpatient 3 DOA b. Time of Injury M 1 farm, street, factory, office and/or investigation, in my 29c. Lice	Other: 4 Nursing Home Vork? Yes 2 No 28 The data and place, 3, y opinion, death occurred onse number	24a. Was an autopsy performed? 1 Yes 200 No. Check only one 5 Residence d. Describe how injuing. If Location (Street a. City or Town, State at the time, date an 29d. Da	pfior to cordeath? 1 Yes 6 Other (Specify ny occurred) and Number or Rura et al. b) and manner at et al. d place, and due to te signed (Month, its signed (Month).	I Route Number, alted. the cause(s)				
	edical Certification; To Be Completed	examiner? 1 Yes 2X No 27. Manner of Death 1X Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a Certifier (Check only one) 2 Medical Examiner	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, building, etc. (Specify) yisician: T. The hest of my knowled inner: On the basis of examination and manner stated.	Outpatient 3 DOA D. Time of 28c. In Injury M 1 A farm, street, factory, office 10 and/or investigation, in my	Other: 4 Nursing Home Vork? Yes 2 No 28 The data and place, 3, y opinion, death occurred onse number	24a. Was an autopsy performed? 1 Yes 200 No. Check only one 5 Residence d. Describe how injuing. If Location (Street a. City or Town, State at the time, date an 29d. Da	pfior to cordeath? 1 Yes 6 Other (Specify ny occurred) and Number or Rura et al. b) and manner at et al. d place, and due to te signed (Month, its signed (Month).	I Route Number, the cause(s)				

			1 - For State Registrar	State of Ma	ryland /		irtment of H tificate of L			giene Reg. No.2	06	01252	
	Physici /Medio		Decedent's Name (First, Middle, Last) HELENA	С.		MUMI	FORD		2. Date of Dea Month JAN.	Day	2006	3. Time of Death 0414 M	
	Examir		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or	Location of Dea	ith	4c. Coun	4c. County of Death				
		4	ATLANTIC GENERA					RLIN			ORCEST		
l A	Funeral Director		5. Social Security Number 6. Sex 222-14-4628	M 2X F	(In yrs. last I	Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		(. Year)	9. Birthpi Count DEL	lace (State or Foreign try) AWARE	
	yland		10a. State 10b. County		10c. City, To	wn or Lo	cation				10	0d. Inside City Limits	
	Ba-f e	Director	DELAWARE SUSSEX		FENW	ICK I	SLAND					1 XYes 2 No	
	with the	Dire	10e. Street and Number RD 3 BOX 292B				10f. Zip Code 19944			10g. Citizen of		try?	
	me 23	Funeral		12. Was Decedent E	ver in U.S.	13. V		spanic Origin? (Specify Yes or No-		SA ace - America	an Indian.	
980	be tited within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or iteme 23a or 28a-f show event, the Madical Examiner must be motified at	by	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	lo		Vas Decedent of Hi Yes, specify Cubar ☐ Yes 2【XNo	n, Mexican, Pue Specify:	rto Rican, etc.)	Spec	ack, White, e	etc.	
15-0	"natu	etec	15. Decedent's Educ (Specify only highest grade	cation completed)	16	a. Deced	ent's Usual Occupa kind of work done of OO NOT use retired,	ition Juring most of w	orking	16b. Kind of I	Business/Ind	ustry	
21215-0036	fited within Hygiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		ONOT use retired, IEMAKER)		OWN	HOME		
pu	be tited tal Hygie d other i	Bec	17. Father's Name (First, Middle, Last)					18. Mother's Na	ame (First, Middle,	Maiden Suma	me)		
Maryland		2	BENJAMIN 19a. Informant's Name/Relationship (Ty)	F.	HALL	05. 44.70.		DAI		MAE	ESH		
	nd 2 atth ar		ELAINE McCABE/DAI	•			g Address (Street a						
ore,	ges 1 an t of Heal if Itam 2 or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R				sition (Name of natory or other place		Date	20c. Location			
Baltimore,	Pagent ont: I		4 ☐ Donation 5 ☐ Other (Specify)			OPVII	LE CEMET	ERY 1/	7/06	BISHOP	VILLE,	MARYLAND	
Bal	permit. Pac Departmen Important: any injury once.		21. Signature of Funeral Service License	In Moi	343	HA	Name and Addres	UNERAL 1			E, DE.	19975	
r			23a. Part 1. Enterwhe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately a cause on each line.										
13	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Athers	oschero		Cardiou	12 sculus	- Wisce	۶۹		Onset and Death	
	Examiner		Sequentially list conditions	Mobrie Destructive Pulmona Discours									
Er.	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	e of):		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	7 1	. = ((ou s.	
	xecute and	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequenc	e of):							
68760,	icate be executed physician and the burial-transit	edical E	L _a										
	ertifica ling ph		IF FEMALE:										
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 24246 9 Unknown	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at 1 9□Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year				
s, P	es that igned b be deta	by Pt	Part II. Other significant conditions con	tributing to death bu	it not resulting	j in the ur	iderlying cause give	n in Part I.	23e. Did to	bacco use cor	ntribute to the	e cause of death?	
ord	w require been si should t	ted							1 🗆 Y	es 2 No	3 🗌 Proba	ably 4 Unknown	
Vital Records,		Completed							autop perfor	24a. Was an autopsy performed? 1 \(\) Yes 2\(\) Xere autopsy findings availa prior to completion of cause death? 1 \(\) Yes 2\(\) Xero			
Vite	siclen: T certificat rector, pa	Be	25. Was case referred to medical examiner?	ospital:	-		104-		eath /Check only or				
ō	Phys or this oral dir	.T	1 ☐ Yes 2 No '' 27. Manner of leath	28a. Date of Injur	y 28b	Outpatien Time of	3 DOA Othe	4 🗆 Nursing	Home 5 Resid			1	
ion	Attending I death. ctor: After y the funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	28c. Injury Work M 1 □ Y	? ′es 2 □ No		on injury occu			
Division	tel or Attend s after death el Director: /	27. Manper of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28d. Describe how inju 28d.									ber or Rural	Route Number,	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical (29a. Certifier 11X Certifying Phys (Check only one) 2 Medical Examil	ician: To the best of ier: On the basis of and manner stat	examination a	lge, death and/or inv	occurred at the timestigation, in my op	e, date and place inion, death occ	e, and due to the durred at the time, o	ause(s) and m late and place	nanner as sta , and due to	ted. the cause(s)	
	with To t	2	29b. Signature and title of certifier	111		7	29c. License	number	2	29d. Date sign	ed (Month, D	ay, Year)	
	Ba		Ap. Name and address of person who co	Cell	ath (line on	<u> </u>	DUE	3269		114	106	>	
_	30		Nelicka N. Borale	lia, us	120	i) (Type, I	and the	in Fe	wet I	steed!	De 1	19944	
2	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 5 20	2. Registra	r's Signature		arest r			-			

		4	For State Registrar	State of N	Maryland		artment of F			Reg. N	Z 111116	5 0	1253
*	Physicia	an	Decedent's Name (First, Middle,						Moi			ear	3. Time of Death
	/Medic	al	Robert 4a. Fecility Name (If not institution,	Euger			Miller 4b. City, Town, o	r Location of C			108, 2 c. County of I		2:40 PM
1	Examin	er	Washington Coun				Hagerst		Joann		Washin		
	Funeral	2		6. Sex 7. /	Age (In yrs. ias	st birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date	of Birth oth, Day, Yea	9		e (State or Foreign
***	Director		219-20-0157	1 X M 2□ F	77	Yrs.	Months Days	Hours	Jul	y 6, 1		ary1a	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation					10d.	Inside City Limits
	Maryli f sho	io	MD Washin	ngton	Hage	rstow	n						1 Yes 2 □ No
	r 28a	Irec	10e. Street and Number	-8	8-		10f. Zip Code			10g. (Citizen of Wha	at Country	?
	th wit	ai D	241 Nottingham	Road			21740			Į	J.S.A.		
	tems tems	uner	11. Marital Status	12. Was Deceder Armed Force	s?	. 13.	Was Decedent of H	lispanic Origin an, Mexican, P	n? (Specify Ye Puerto Rican, e	s or No- etc.)	14. Race - Black, V	American White, etc.	
36	be filed within 72 hours after death with the Maryland nat Hygiene. do other than "natural", or items 23a or 28a-f ahow event, the Macical Examinar must be natified at	by Funeral Director	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	led 1 TYes 2 If Yes, Give Year or Date:	⊐№ 1945 s: 1946		1□Yes 2XINo	Specify:			Specify:	White	a
9	2 hou	ted	15. Decedent'	's Education	- 1940	16a. Dece	dent's Usual Occup		· · · · · · · · · · · · · · · · · · ·	16b.	Kind of Busin		
215	within 7. ene. than "n	Completed	(Specify only highes	College (1-4c	or 5+)	life.	kind of work done DO NOT use retired	during most of d)	r working				
21	e filed within at Hygiene. other then	Con				Ammur	itions	40 14-15-3	N (Final		my Dep	ot	
and	I be fil ntal H ed oth	To Be	17. Father's Name (First, Middle, L B. Miller	_ast)					Name (First, H. Sp		en Sumame)		
Maryland 21215-0036	should be nd Mental r marked o	Ŧ	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Maili	ng Address (Street				y or Town, Sta	ite, Zip Co	ode)
	alth ar 27 is rr trau		Catherine R. Mil	ller/Wife		241	Nottingha	m Road	, Hage	rstown	, MD 2	21740	
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Ments Important: If Itam 27 is marked any injury or other traumatic e ance.		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation	2 □Removal from Sta	COL	nce of Dispo metery, crei	osition (Name of matory or other place	ce)	Date	20c.	Location - Cit	y or Town	, State
Ĕ	Pagment ment ant: i		4 Donation 5 Dother (Sc	pecify)			n Cemeter		12/200		gersto		
3alt	Depart Import Import In in		21. Signature of Funeral Service L	_icensee	_		2. Name and Addre					_	
e ^{ab} jo	40284		23a. Part1. Enter the disease, or	complications that cause	sed the death		601 Penns	-			rstown		21742
*	Discolation		shock, or heart failure. List of Immediate Cause (Final)	only one cause on each	n line.		,			,		fn	terval Between nset and Death
	Physician /Medical		disease or condition resulting in death)	a. Seps	as a conseque	ence of):							
	Examiner		Sequentially first conditions	b. AURT	16	RAF	T IMFEC	TION	1 RUP	TURE			
	Sit ad	iner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseque	ence of):			•				
	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	c	as a conseque	ence of):							
8760,	cate be exc physicien a the burial	ical E											
9	ifficate ig phy as the	B		- U							I		
Вох	eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor 1□Live birth	me of pregnan		∃Ectopic pregnanc	,			23d. Date o	,	Voor
	at the dear by the att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant 9☐ Unknowr	tat time of dea		Other (specify)				Month	Da	y Year
P.0.	that the		Part II. Other significant condition	ons contributing to deat	h but not result	ting in the u	inderlying cause giv	ven in Part I.	23	e. Did tobacc	o use contribu	ute to the d	cause of death?
Vital Records,	uires t signé ld be	d by	UNOSERSIS,						,	1 🗆 Yes	2 No 3	☐ Probabl	y 4 DUnknown
COL	w requir s been si should	Completed	HUMOKHAG	12. I40	PSIAS	Me	MATOR	10	-	a. Was an	24b. We	re autopsy	findings available
Re	The lay	ошь						•	_	autopsy performed Yes 22		r to compt th? Yes 2[fetion of cause of
ita	sician: T certificat rector, pa	BeC	25. Was case referred to medical examiner?					26. Place of	f Death (Chec				
of V	Physic this ce al dire	To	1 ☐ Yes 2 ☐ No	Hospitaf: 1 Inp		R/Outpatie	1 3 DOX		ing Home 5			(Specify)	
ň	ding P. h. After (ion:	27. Manner of Death 1 □ Natural 5 □ Pendin	9	njury Day Year)	28b. Time o Injury	Wo	ryat rk? ∣Yes 2.⊟No		scribe how in	ifury occurred		
Division	Attsndii death. ctor: A y the fu	ficat	2 Accident investig 3 Suicide 6 Could r	not be 28e. Place of	Injury - At hon	ne, farm, st	reet, factory, office			cation (Street	and Number	or Rural R	oute Number,
D	after Dire d in b	Certification:	4 Homicide	building,	etc."(Specify))			Cit	y or Town, St	ate)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C		ng Physician: To the be Examiner: On the basi	s of examination								
	o the	Mec	29b. Signature and title of certifier	and manner	stated.		29c. Licens	se number		29d. (Date signed (/	Month, Day	y, Year)
	- s - o		· (VN)		MP		DO	0623	327	ŧ	1910	6	
,			30. Name and address of person	2		23а) (Туре,		11	. 1				
纠	-011		DI Banen		08 M	ull	Xt.	Hug.	Md	217	40		
	Sta Regista		31. Date filed (Month, Day, Year)	2006	istrar's Signatu	My A	andel	1					

MARTHA MUSKIE 06-0043 Unpend item# 22, Property of Print in Black Indelible Ink. Ensure All Copies Are Legible. RKD State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Martha JANUARY Muskie 2006 11:50A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 217 BOOTH STREET MONTGOMERY GAITHERSBURG 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2X F Yrs. Director 218-78-4143 47 Dec. 17, 1958 Main Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d Inside City Limits 28a-f ehow r then "natural", or items 23a or 28a-1 ehor the Medical Exeminer must be notified at 1 Yes 2 No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 217 Booth ST 20878 Apt. 414 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Vocational REhabilitation 16b. Kind of Business/Industry Special Education and end Mental Hygiene. Ie markad other then Elementary/Secondary (0-12) College (1-4or 5+) Rehabilitation 5+ Specialist permit. Pages 1 and 2 should be file Depertment of Health end Mental Hy Important: If Item 27 Ie marked onthen ynjury presher traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edmund Sixtus Muskie Jane Francis Gray 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3908 Virgilia ST. Chevy Chase, Maryland 20815 Date Date 20c. Location - City or Town, State Edmund S. Muskie, Jr. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat'l Cem. Jan. 20,2006 Arlington, Va. 22. Name and Address of Facility Joseph Gawler's Sons, INC. 21. Signature of Funeral Service Licensee Willia 5130 Wisconsin Ave. N.W. Washington D.C. 20016 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ng physicien and es the burial-transit certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery وَ 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a Division of Vital Records, P.O. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 cate hes been sig , pege 2 should b Lupus Erythematosus Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate hes autopsy performed? 1 Yes 2 □ No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) SCENE 1 TYes 2 □ No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After Certification: 28c. Injury al Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending death. 1 ☐ Yes 2 ☐ No. investigation м 2 Accident To the Hospital or Attency within 24 hours effer death To the Funerel Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the hest of my knowledge, death contrad at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State

Registrar

Medical

(Check only one)

29b. Signature and title of certifier

ANA RUGIO 31. Date filed (Month, Day, Year) JAN 10 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, MA 32. Registrar's Signature 111 PENN STREET BALTIMORE MARYLAND 21201

29d. Date signed (Month, Day, Year)

JANUARY 3, 2006

29c. License number

O.C.M.E.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year MICHAEL TIMOTHY MURPHY JANUARY 11, 2006 11:15 MM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 3590 FOREST VIEW DRIVE WALDORF CHARLES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours **₩** 2□ F 63 Yrs. Director 579-54-1207 7,1942 WASH. JUNE Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at 1 Yes XXNo Directo MARYLAND CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3590 FOREST VIEW DRIVE 20601 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ "any injury or other traumatic even." 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married XX Married 1 ☐ Yes 2XXVo Specify: Completed by Specify 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ASBESTOS INSTALLER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOHN F. MURPHY MARY BRONSHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANICE S. MURPHY-WIFE 3590 FOREST VIEW DRIVE, WALDORF, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ty Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Ţ TRINITY MEMORIAL GDNS. 01-14-06 WALDORF, MD 21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused the deeth. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician and the for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2☐(No I or Attending Physician: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home sidence 6 Other (Specify) ² 20 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Acoident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Fo the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KRISHAN 707 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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	be de ched	ysic	1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of d	leath 5∟	Other (specify	')						,	, •••
	law requires that the death certific as been signed by the attending p should be detached for use as		Part II. Other significant conditions	contributing to death bu	it not res	ulting in the ur	nderlying cause	given in	Part I.	23e.	Did tobac	co use cor	ntribute to t	he cause of o	death?
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Σ .	To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: Atter this certifical completely filled in by the funeral director.		29a. Certifier 1 Certifying	Physician: To the best o	f mv kno	wledge, death	occurred at th	e time da	ate and plac	e and due to	the caus	ea/s) and m	annar as s	tated	
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			30. Name and address of person wh		ath (Iten	n 23a) (Type, I	Print)								
			RAJBINDER GILL	M.D. P.O.B	OX 6	40 THR	EE NOTO	H RO	AD HO	LLYWOO	D,MD	. 206	36		
			31. Date filed (Month, Day, Year)	32 Registra											

DANIEL PEREZ MASARIEQOS 06-0014 Amend Unpend Please Type propriet in Flack indelible link. Ensure All Copies Are Legible. RKD State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JANUARY 2006 9:15 A. M Pérez Mazariegos Daniel /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 18240 LePore ROAD Lot 21 MARYDEL CAROLINE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours M 2□F **Director** 38 1/29/1967 Guatemala Usuel Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits rei', or iteme 23a or 28a-f ehow Examiner must be notified at Director MD Caroline 1 Yes 2 No Maryde1 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 18240 LePore Road Lot 21 21649 Funeral <u>Guatemala</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 X Yes 2□ No Specify: Guatemalan ģ Specify: Hispanic 3 ☐ Widowed 4 ☐ Divorced "neturei", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) agriculture 03 laborer permit. Pages 1 and 2 should be file Deportment of Heelth and Menial Hy Important; if Item 27 is marked oth any lighty or other traumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rigoberto Pérez Felesita Mazariegos 19a. Informant's Name/Relationship (Type, Printbrother—in-Iaw 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Otilio Morales Perez 18240 LePore Road Lot 21 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jardin del recuerdo NA Guatemala 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Alcohol Intoxication /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ettending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Iclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) ed by the e Physi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? as been signe a 2 should be c þ 1 ☐ Yes 2 ☐No Completed 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No autopsy performed? page certificate 1 Yes 2 No funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 Nother (Specify) SCENE. 2 □ No 2 1X Yes his 28a. Date of Injury Fix 28b. Time of Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred unk Alter 1 Natural 5 Pending investigation 1/1/06 8:00 A 1 ☐ Yes 2 📆 No 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 18240 Lepore Road 4 | Homicide within 24 hours after To the Funerel Dire Found in residence Lot 21 Marydel, MD 21649 t Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Mynle JANUARY 2, O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRYDMID 0000 111 PENN STREET BALTIMORE, MARYLAND 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dev **Physician** Sister Elaine McCauley 13, 2006 /Medical January 1:00 P.M. 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Emmitsburg
If Under 24 Hrs.
Hours | Min. | 8. Date of Birth (Month, Dey, Year) St. Vincent Care Center Frederick 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🖫 F Director 89 July 23, 1916 Washington,DC 229-68-4136 Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours after deeth with the Merylend nant of Heelth end Mental Hyglena. 10a. Stete 10b. County th end Mental Hyglena. 7 is marked other than "natural", or itams 23s or 28s-f ahow traumatic event, the Medical Examines must be notified at 10c. City, Town or Location 10d. Inside City Limits 1⊠Yes 2 No Directo <u>Frederick</u> Emmitsburg 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21727 335 South Seton Avenue U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: \$ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Religious Community Elementary/Secondary (0-12) College (1-4or 5+) College 5+ Teacher Daughters of Charity 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Patrick McCauley Mary Joseph Byrne 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Depertment of Heelth e Important: if item 27 is any injury or other trat pncs. 333 S. Seton Avenue, Emmitsburg, MD Sister Camilla Harant 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State 1/16/2006 4 ☐ Donation 5 ☐ Other (Specify) EMMITSBURG, MD. 21727 JOSEPH'S P.H. 21. Signature of Funeral Service Licenses 22. Name end Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727-0427 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cadse on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence by Physician/Medical Examiner Attending Physician: The law requires that the deeth certificate be executed attending physiclen and for use es the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as e consequence of): ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cartificata has been sign irector, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy 1 Tes 2 X No 1 ☐ Yes 2 ☐ No director Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this : After this 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Neturel 5 Pending death. 1 ☐ Yes 2 ☐ No investigetion 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 To the Hospital o within 24 hours af To the Funeral Di completaly filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Dey, Year) JANUARY 14, 2006 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 310 S. SETON AVE., EMMITSBURG, MD. 21727

DHMH 16 Rev 6/95

State

Registrar

ALAN CARROLL.

JAN 2 0

2006

31. Date filed (Month, Dey, Year)

32 Registrer's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Juanita Grace Newell 10 2006 MANUary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 07/25/1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 215-26-8453 74 Director MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or Iteme 23s or 28s-f show Exactost must be notified at 1 ☐ Yes 2 ☐ No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 US 20014 Rosebank Way Apt. 148 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: þ 3X Widowed 4 □ Divorced ieted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Comple Elementary/Secondary (0-12) 12 than College (1-4or 5+) al Hygiene. Cook Restaurant permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked other eny Injury or other traumatic event, p.nca. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Howard E. Householder Susan Jane Hornbaker 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly A. Poole / Pers Rep 507 Get-A-Way Lane, Bahama, NC 27503 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/13/2006 4 Donation 5 Other (Specify) Cedar Lawn Mem Park Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** YE ANS disease or condition resulting in death) CHLOPIC OBSTRUITION PULMONARY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 → No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 🗷 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 🖃 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funaral Director: 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0001040 01-10-2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 322 COHEN, E. ANTIETAM HAGENSTOWN, MID 21740 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State JAN 11 2006 Registrar

			1 - For State Registrar	State of Maryland /		nt of Health an		giene 006	01262
	# 18 V	-1	Decedent's Name (First, Middle, Las.	t)	-		2. Date of De	ath	3. Time of Death
	Physicia /Medic	-	Andrew	Earl Newman			Month January	8, 2006	9:07 a.M.
	Examin		4a. Facility Name (If not institution, give			y, Town, or Location of D		4c. County of Deat	
			St. Mary's H	ospital		Leonard	town	St. N	Mary's
92 ⁹⁴	- Funeral		5. Social Security Number 6. Se	7. Age (In yrs. last b	Month	er 1 Year If Under 24	Hrs. 8. Date of Birt Min. (Month, Da		hplace (State or Foreign untry)
	Director		116-30-4821	M 2□F 67	Yrs.				New York
	and *		Usual Residence of Decedent 10a. State 10b. County	10c, City, Tor	wn or Location				10d. Inside City Limits
	l eho	o							1 ☐ Yes 2 € No
	28a-	Directo	Maryland St. 10e. Street and Number	Mary's		ington Park		10g. Citizen of What Co	untar?
	with		46868 Flower	Danders	101. 2	20653		-	•
	ne 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Dec			United Stat	
· O	riter	Fun	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No 1956-		edent of Hispanic Origin ecify Cuban, Mexican, P	uerto Rican, etc.)		e, etc.
Ö	urs a		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1978	1 Yes	2 No Specify:		Specify: Wh	nite
2-0036	within 72 hours after death with the Maryland ene. Then "natural", or items 23a or 28a-f ehow he Madical Examiner must be notified at	Completed by	15. Decedent's Ed (Specify only highest grad		a. Decedent's Us	ual Occupation work done during most of	working	16b. Kind of Business/	Industry
2121	thin i	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	lite. DO NOT	use retired)	Working		
2	filed with Hygien Sther the	Con	12		Metal:	1		U.S. Nav	y
D D	d oth	e	17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Middle,	Maiden Surname)	
Maryland	2 should be filed within 72 hours after death with the Marylan and Menth Hygiens is marked at Hygiens is marked other then "natural", or liems 23a or 28a-1 show aumatic event, the Madical Examinat must be notified at	٩	Andrew Jack				ice Bayea		
Jai			19a. Informant's Name/Relationship (T					er, City or Town, State, 2	, ,
	1 and Health em 27 ther tr		Patricia Jean Ne	<u> </u>			The state of the s	Park, MD 2	
altimore,	Pages 1 nent of H int: if ite iry or of		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □	Removal from State	of Disposition (A ery, crematory of	other place)	Date	20c. Location - City or	Town, State
<u>E</u>	tant:		4 □ Donation 5 □ Other (Specify					Leonardtown	
Bai	permit. Pages Department of important: if if eny injury or c once.		21. Signature of Funeral Service Licen:	17/4 January	22. Name	and Address of Facility	Brinsfield	Funeral Ho	ome, P.A.
	40200	0 10	Kyle S. Simo						20650-0279
L. L.	\$		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	one cause on each line.					Approximate Interval Between Onset and Death
kin.	Physician		Immediate Cause (Final disease or condition resulting in death)	a Small	Cell 1	ong Cance.	- Metas	tatic	3 months
	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):	9			
	A 1	_	Sequentially list conditions,	b. Due to (or as a consequence					
	bed nsit	Examiner	Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	9 OI).				
•	and al-trar	xan	that initiated events resulting in death) Last	c. Due to (or as a consequence	e of):				
760,	Attanding Physician: The law requires that the death certificate be executed rideath. crotath. sctor: Atter this certificate has been signed by the attending physician and property the funeral director, page 2 should be detached for use as the burial-transit.	icai E							
687	ficate physis the			O.					
Вох (eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date of deli	iven
ŏ	atte	ciai	in the past 12 months?	1 Live birth 2 ☐ Fetal deat 4 Pregnant at time of death	th 3 ⊟Ectopic 5 ⊟ Other (Month	Day Year
P.O.	t the de by the a tached	nysi	9 Unknown	9□ Unknown					
	signed b	by PI	Part II. Other significant conditions co	ontributing to death but not resulting	in the underlying	cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
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00	s been si should	Completed					24a. Was	an 24b. Were au	topsy findings available
Re	The lay	mc					autop perfo	osy prior to death?	completion of cause of
ta	ician: Th certificate ector, pag	Ö	25. Was case referred to medical			36 Place of	1 ☐ Yes Death Check only o		2 1 No
>	ysician: is certific director,	To B	examiner?	Hospital:	Outpatient 3 1	Othor	100	dence 6 Other (Spec	nifie)
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0	nding F ath. r: After e funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury M	1 ☐ Yes 2 ☐ No			
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ā	tal or s afte si Dir	Certification:	TOTAL STATE OF THE PARTY OF THE	building, etc. (Opechy)			City or Tov	vri, State)	
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Ph	y viction: To the best of my knowledge niner: On the basis of examination a	ga, daath cocure	d at the time, data and p	lace, and due to the	cause(s) and manner as	statad.
	the H in 24 the F iplete	Medical	one)	and manner stated.	indroi investigatio	on, in my opinion, death	occurred at the time,	date and place, and due	to the cause(s)
	To the within 2 To the Complet	Σ	29b. Signature and title of certifier			9c. License number		29d. Date signed (Monti	n, Day, Year)
		1	Kishe			050686		19106	
			30. Name and address of person who of						
			GULDED & CHA	ABRA MD STA	MRRY! H	OSPITAL PO	Bx527 L	EONARDTON	N, MD-20650
35	Sta		31. Date filed (Month, Day Year) 0	2005 32. Resistrar's Signature	E ASSES				
100	Registr	ar			1	**			

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** -10N(+ 06 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Sall Slowy r1 Year | If Under 24 Hrs. the OSDICE WI Com 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 258 F Hours Director 222-64-4446 43 Sept. 16, 1962 Vietnam Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or items 23a or 28a-f show or other traumatic event, the Madical Examiner must be notified at Completed by Funeral Director 1 Yes 2 No MD Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 102 Maryland Ave. 21643 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 1 No Specify: Specify: 3 Widowed 4 Divorced Vietnamese "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ng most of working al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) owner/operator nail salon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Moi Van Nguyen Muoi Thi Le 2 nt of Health and A 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pat Lee 202 Johnson St., Cambridge p.r. MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Salisbury Crematory 1/6/06 Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARCINOMA **Physician** /Medical Due to (or as a consequence of) **Examiner** NEUMON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed buriaj-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 4☐ Pregnant at time of death 5 Other (specify) detached been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 99 1 Yes 1/2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physicien: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Inpatient 2 ER/Outpatient 3 DOA this ate of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation death. М 1 Yes 2 No filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1714256 Oque us 30. Name of address of person who completed cause of death (Item 23a) (Type, Print) (DSTAZ HOSPICE AT JAMES W ISAACS THEEDSHELD SACISBUT) 31. Date filed (Month, Day, Year) 32. Registar's Signature State Registrar

AEM 06-00034 Will:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ia	m Wualt	er	-Osorio 1- State Registrar	State of M	laryland		rtment			and M	ental Hy	/giene Reg. No.	006	01264
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Las William Walter (4a. Facility Name (If not institution, give E/B Rt. 50	Osorio)			rown, or Cheve	Location o	of Death	2. Date of D Month Janua	ry 1,	2006 County of Dea ince Ge	3. Time of Death 9:28 P M eorge's
	Funeral Director		5. Social Security Number 6. S 557-91-6215 Usual Residence of Decedent	9x 7. A(☐ M 2 ☐ F		ast birthday) 29 Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D 10/20/	1976	l Co	thplace (State or Foreign ountry) dores
	e Maryland Sa-f ehow	ctor	10a. State 10b. County TALBOT			Town or Lo		Uni	t# 29	9/ Т	rappe'			10d. Inside City Limits 1 ☐ Yes 2 ◯ No
	an with th	I Dire	10e. Street and Number 2317 Lovers Ln Ut	nit #29			10f. Zip	Code 1673				-	en of What Co dores	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show amy injury or other traumatic event, the Medical Examinat must be notified at an once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Tyes 245 If Yes, Give Year or Dates:	? I No	-	Vas Decede Yes, speci	ent of His			city Yes or N Rican, etc.)	0- 1-	4. Race - Ame Black, Whit	
21215-0036	d within 72 ho piene. r than "natur the Medical."	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12) Unknown	lucation de <i>completed)</i> College (1-4or	5+)	16a. Deced (Give life. Un	ent's Usual kind of work OO NOT use KNOWN	l Occupa k done d e retired)	tion u <i>ring m</i> osi	t of working	ng		d of Business	/Industry
Baltimore, Maryland	ould be filed Mental Hyg Marked othe	To Be C	17. Father's Name (First, Middle, Last) Jose' Porfirio Mo						Irma	Me1				
Mar	nd 2 sh alth and 27 is m ir traum		19a. Informant's Name/Relationship (Type, Print)			-						Town, State, 2 D 2167	•
lore,	iges 1 a nt of Heam : If Item or othe	-	20a Method of Disposition 1 Burial 2 Cremation 3		20b. Pl	ace of Dispo	sition (Nam natory or oti		9)	D	ate	20c. Loc	ation - City or	
altin	mit. Pa partmer portant y Injury £8.		4 □Donation 5 □ Other (Specifical Signature of Funeral Service Licentage 1)	-	/	Unknov	VII . Name and	Addres	1	Jnkno y			known over S	t.
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	Physician /Medical Examiner physician up prize physician and physician and physician are the physician phy	lical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as) Thus a consequence of a consequence of the conseq	ence of):	ఆక్							Initerval Between Onset and Death
P.O. Box 68	law requires thet the death centificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetaf	death 3	Ectopic pre					23	3d. Date of del	ivery Day Year
rds, P	w requires thet s been signed b should be deta	þ	Part II. Other significant conditions c	ontributing to death I	but not resu	Iting in the ur	iderlying ca	use give	n in Part I.			tobacco us Yes 2	1	the cause of death?
al Reco	The ate h page	Completed									24a. Was auto perf 1 Yes		24b. Were au prior to death? 1 1 es	itopsy findings available compfetion of cause of 2 No
Ţ	ysicial lis certif directo	To Be	25. Was case referred to medical examiner? XXYes 2 □ No	Hospital: 1 🗌 Inpati	ient 2 🗆 E	ER/Outpatien	3 DO	Othe	c.		(Check only ne 5 ☐ Res		(Spe	afy) Scene
Division of Vital Records,	To the Hospitel or Attending Physicien: within 24 hours elter death. To the Funerel Director: After this certifica	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		ay Year)	28b. Time of Injury 21:27	М	Sc. Injury Work 1 Y	at ?	No D	8d. Describe	how injury	OCCURRED	SECT, ROLEDON WITH FIXED WITH FIXED WITH FOUND Number,
Š	To the Hospitel or Attentwithin 24 hours efter deatl To the Funeral Director: completely filled in by the	edical Certi	4 Homicide determined 29a. Certifier 1 Certifying Ph	building, e	t of my know	vledge, death	occurred a	it the time	e, date and	d place, a	City or To	CAUSE(S) a	tevenu	PRINCEGEORY:
	o the Horitin 24 orthe Fu	Medi	one) 29b. Signature and title of certifier	and manner s	tated.			License			o at the time.		signed (Monti	
			> Margarte	meyen	ll			OCME	E			Jar	nuary 2	, 2006
	X1-		30. Name and address of person who	street, Ba	death (ftem altimo	^{23a)} (Туре, re Mar	ryland	212	201 M	Any	DRITT	A. 10	CORELL	w
,	Sta Registi		31. Date filed (Month, Day, Year) JAN 0 5 2	32. Regist	trar's Signat		60	À		/-				

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			For State Registrar		St	ate of I	Marylan	,	artmen e <i>rtificat</i>				Mental	Hygier	21111	6	01265
		φ.	Decedent's Name	e (First, Middle,	Last)								2. Date Monti	of Death		Year	3. Time of Death
	Physici /Medi		Jennie Ja	ackson (Oldha	m							01	Oã			19:13°M
	Examir		4a. Facility Name (I				er)		4b. City,	Town, or	Location	of Death	1		4c. County o		
		03 Y.	PENINSULA 5. Social Security N	a legio	na/	med.	iCa/ C Age (In yrs.	enter) If Under	Alie 1 Year	Shur g	24 Hrs.	8. Date	of Righ	Will		
	Funeral: Director		160-03-78		1 🗆 M		88	Yrs.	Months		Hours	Min.	July	17,13	317 F	enn	place (State or Foreign offry) sylvania
			Usual Residence of														
	urylan show		10a. State	10b. County				y, Town or								1	10d. Inside City Limits 1 XYes 2 No
	8a-f	ecto	Maryland	Wicomi	CO		Sal	lisbur		0.1-				10-	Citizen of Wh		
	hours after death with the Maryland turel, or frems 23s or 28s-f show at Expression must be notified at	Funeral Director	10e. Street and Nur			Mesos	Deitze		10f. Zip	804				-	SA	iai Coui	iu y r
	leath ns 23	eral	911 West	Schuma	12. V	Vas Decede	ent Ever in U	.S. 13	B. Was Dece		ispanic Or	rigin? (Sr	pecify Yes		14. Race		can Indian,
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12	within ane. then	du	Elementary/Seco	ondary (0-12)	0	College (1-4	or 5+)		emaker	se reiired	')			D	omesti	С	
9	Hygie Hygie other		17. Father's Name	(First, Middle, L	ast)						18. Moth	ner's Nan	ne (First, M	liddle, Maid	len Sumame)	
Maryland 21215-0036	lid be lental ked c	To Be	William R	avmond	Thoma	as					Jenr	nie 1	Patto	n			
ary	shou and M mar	20 3	19a. Informant's N	ame/Relationsh	р (Туре, Е	Print)									y or Town, S		Code)
	and 2 saith a n 27 i		Nancy Rec	dish/Da	ughte	er					Dr.	Sal		-	21801		
ore	of He of He if item		20a. Method of Dis	position Cremation	3 ∏Remo	val from Sta	20b. F	Place of Dis	position (Na rematory or Memol	me of other place	Park		Date		. Location - C		
Ĕ	Pag menf ant: l			5 ☐ Other (Sp			MIC					Τ/	7/200	06 Sa]	Lisbur	y,Ma	ryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: if fem 27 is marked other then "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exembles must be notified at once.		21. Signature of Fu	Ineral Service L	louisee Louisee	2/2	CFS	P	22. Name a HOLLOW	ay F	ss of Facil unera iill I	al H	ome P Salis	.A. burv,	MD 21	.804	
3			23a. Part I. Enter t shock, or hea	he disease, or o	omplicationly one ca	ons that cau	sed the deat	h. Do not e	enter the mo	le of dyin	ig, such as	s cardiac	or respirat	ory arrest,			Approximate Interval Between
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Aldham Is, P.O. Bo	the all	sici	1 ☐ Yes 2 l	☑ No		4□Pregnan 9□Unknow	nt at time of o	death !	5 ☐ Other (s	oecify)				-			
2 .9	that the sed by detact	Ph	Part II. Other signi		s contribi	uting to deal	th but not res	sulting in the	underlying	cause giv	en in Part	I.	23e.	Did tobacc	co use contril	bute to t	he cause of death?
Olc ds,	8 58	d by							, •					1 🗆 Yes	2 □ No 3	3 🗌 Proi	pably 4 Unknown
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A 8	The law ate hes b	dmo											1.0	autopsy performed Yes 2 🗗	? de	ath?	ompletion of cause of 2 No
Jenai of Vital	ician: Th certificate rector, pag	0	25. Was case refe	rred to medical	-1/-			- 5			26. Plac	e of Dea	1 Check		NO TO	7 : 62	2 140
\varphi \subseteq \subseteq \subseteq	Physician: r this certific ral director,	To B	examiner?	No	Hosp	ital: 1 🗆 Inp	atient 2	ER/Outpat	ient 3 🗆 D	OA Oth	er: 4 □ N	lursing H	lome 5	Residence	e 6 □Othe	r (Speci	fy)
			27. Manner of Dea	th 5 🗆 Pending	2	8a. Date of (Month,	Injury Day Year)	28b. Time Injur		28c. Injur Wor			28d. Des	cribe how i	njury occurre	d	
siol	Attending r death. sctor: After	catio	2 Accident	investig	ation of he				М		Yes 2	No					
Division	2 th 12 is	Certification:	4 Homicide	determi	ned 2	8e. Place of building	f Injury - At h j, etc. <i>(Speci</i>	iome, farm, fy)	street, facto	y, office				tion (Stree or Town, S		r or Hur	al Route Number,
	Hospital 14 hours a Funeral I jely filled		29a. Certifier	1 Certifying	Physicia	n: To the h	est of my kn	nwiedne de	ath occurre	l at the tu	me date a	and place	and due	to the caus	e(s) and man	ner as	stated
	H 4 H S	edical	(Check only one)	2 Medical			is of examina										
_	To the To the pomple	₹ e	29b. Signature and	d title of certifier					29	c. Licens	e number			29d.	Date signed	(Month,	Day, Year)
	0	3	> 2ste	Not						005	7359	,		Jo	n. 5	15	2006
_			30. Name and add	ress of person of			of death (Ite			JAL	-15B4	iky	70	×1804	,		
		ate	31. Date filed (Mor	nth, Day, Year)		32 Be	istrar's Sign	ature									
¥.	Regist	ırar		JAN 0	0 200	0	men	K	Good	1							

		•	For State Registrar	State of M	laryland		artment of He			giene Reg. No.	/ IIII h	01266
			Decedent's Name (First, Middle, Las	t)					2. Date of De	ath		3. Time of Death
	Physicia		Marv Eliza	abeth C	dell				Jan	3 Day	2006	12:00p ^M
	/Medic Examin		4a. Facility Name (If not institution, give)		4b. City, Town, or	Location of Death			County of Death	12.000
	CXUIIIII	ŭ.	Longview N	ursing H	Iome		Manch	ester			Carrol	
	Funeral		5. Social Security Number 6. Se	7. A	ge (In yrs. la	st birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th		place (State or Foreign ntry)
	Director		356-18-3090	□M 2½ДF	90	Yrs.	Wionins Days	110013	05-05			ryland
	pu 🖈	-	Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation					10d. Inside City Limits
	sho	5										1 StYes 2 No
	ith the Marylan or 28a-f show	Director	10e. Street and Number	imore	C	atons	ville 10f. Zip Code			10a. Citi	zen ol What Cou	ntry?
	With with	큡	715 Maiden Che	oias Tau			2122	8		rog. Om	USA	
	death with the Maryland ms 23a or 28a-f show r must be inclined at	era	11. Marital Status	12. Was Decedent	t Ever in U.S	i. 13. V			pecify Yes or No	- 1	14. Race - Ameri	can Indian,
2	after or Ite	by Funeral	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	? HNo		Vas Decedent of His fYes, specify Cubar I□Yes 2 12 No		Rican, etc.)		Specify: White,	etc.
-003g	72 hours "natural", edicel Exe		15. Decedent's Ed		·	16a. Deced	lent's Usual Occupa	tion		16b. Kii	nd of Business/Ir	
0	in 72 n "na Nedic	Completed	(Specify only highest gra-	de completed)	(5.1)	(Give life.	kind of work done di OO NOT use retired)	uring most of wor	king			,
7		E	Elementary/Secondary (0-12)	College (1-4or 4	5+)	T	'eacher				Educati	ion
ana	be filed ital Hygi id other event, i	au l	17. Father's Name (First, Middle, Last)					18. Mother's Nan	ne (First, Middle,			
<u>a</u>	uld be Aental rked c tic ev	To B	William Wa	alter W	Vilhe:	lm		Grace	Alban			
a	2 should be and Menta is marked raumatic ev	•	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	g Address (Street a	nd Number or Ru	ral Route Numbe	er, City or	r Town, State, Zij	Code)
, <u>z</u>	12 ten		Dennis L. Will	nelm - Ne		3008	Tracey	's Stor	e Rd.	Pa	rkton,	MD 21120 own, State
o C	es 1 a of Hea fitem rothe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Romaval Iram State	20b. Pla	ace of Dispo metery, crer	sition (Name of natory or other place)	Date	20c. Lo	cation - City or T	own, State
	Pages nent of ant: If it ury or o		*4 □ Donation 5 □ Other (Specify		For	rest	Baptist	01-	06-06	ıqU_	perco.M	laryland
Dail	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Lices		1005	50 9	. Name and Address	s of Facility				_
			23a. Part1. Enter the disease, or comp	lications that cause	ed the death.						ad Find	Approximate Interval Between
	Physician		shock, or heart failure. List only immediate Cause (Final		-heir	200	s de	conent	56			Onset and Death
,	/Medical		disease or condition resulting in death)	a	s a conseque		3 0	-110 1	1			10 412
	Examiner			_								
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9/9	cate be executed bhysician and the burial-transit	dlcal		d								
õ	ing pl	Med	IF FEMALE:						-			
ŏ	ath ce ttendi or usé	lan/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Fetal o	death 3□	Ectopic pregnancy			2	23d. Date of deliv Month	ery Day Year
5	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant a 9□ Unkn <i>o</i> wn	at time of dea	ath 5∟	Other (specify)					
J.	that led by deta		Part II. Dther significant conditions co	ontributing to death	but not resul	ting in the u	nderlying cause give	n in Part I.	23e. Did to	obacco u	se contribute to t	he cause of death?
ďs,	puires n sign ald be	d by	HTN, CA	LD.					101	res 2	No 3□ Prol	pably 4 □Unknown
<u> </u>	w require been si should I	Completed							24a. Was	an	24b. Were auto	opsy findings available impletion of cause of
ě	The lar	шc								rmed?	death?	impletion of cause of 2 No
			25. Was case relerred to medical					26. Place of Dea	1 ☐ Yes	2 X No	1 Yes	214 110
>	ysician: iis certific director,	To Be	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpat	tient 2 🗆 E	R/Outpatier	t 3 DOA Othe	-			6 □Other (Specia	(v)
Ö	g Phys er this eral di		27. Manner of Death	28a. Date of Inj (Month, D	jury (2	28b. Time of		at	28d. Describe I			
0	nding F ath. r: After e funer	atlo	1 → September 1 → September 2 → Accident September 2 → Accident September 1 → Septemb		ay roar/	піцату		: ′es 2 □ No				
DIVISION	Atte	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of II	njury - At hon	ne, farm, str	eet, lactory, office		28f. Location (5 City or Tox	Street and	d Number or Rura	al Route Number,
5	tal or satte al Dir ed in	Certification;	· - 11011110100	Dollding, C							, 	
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely lilled in by the funeral director,	edical	29a. Certifier (Check only one) 12 Certifying Ph	ysician: To the bes niner: On the basis and manner s	of examination	vledge, deatl on and/or in	n occurred at the tim restigation, in my op	e, date and place inion, death occu	, and due to the rred at the time,	cause(s) date and	and manner as s place, and due t	stated. o the cause(s)
	vithii To th	Me	29b. Signature and title of certifier	~ ~ ^			29c. License				e signed (Month,	-
) .	WITL		- Columnia	Je com	,		DE	51705		1-	4-2	2006
	W-6		30. Name and address of person who		death (Item	23a) (Type)	Print) D	5 M	estmin	13/20	2 m	DALIEN
	`		M. PANSURIYI 31. Date liled (Month, Day, Year)				114)			-10	4711	N 21101
	Sta Registr			400	trar's Signati		1 4					
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Physics in Description Annual Color Middle, Last) Physics in Description Company Callums Olivor Confirman Numbers of Company Callums Olivor Confirman Num			•	1 - State Registrar		Ce	rtificate of E	Death	R	eg. No. U U	16	0126/
Personal Residence Persona	I	Physici	an	1. Decedent's Name (First, Middle, Last)							Year	3. Time of Death
Coffman Nursing Home Financial Director Continued		/Medic	al	Betty Eleanor Cu 4a. Facility Name (If not institution, give s	llums Oliv	ver	4b. City, Town, or	Location of Death	Januar			7:45 PM
Comparison Com				Coffman Nursing	Home					Washi		
Many Land Washington Wash				236–38–1459					(Month, Day,	Year)		
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Typicital part of the part of	980	urs after dea el', or items	by	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 24∑ N If Yes, Give	ver in U.S. 13.	_		cify Yes or No- Rican, etc.)	Blac	ck, White,	etc.
Typicital part of the part of	2 2	72 ho	eted			16a. Dece	dent's Usual Occupa	tion	na	16b. Kind of Bu	usiness/Ind	dustry
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Continued and Continued and		iled w tygier ther ti		17 Father's Name (First Middle ast)	4			18 Mother's Name	(First Middle II			esidence
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Continued and Continued and	ē,	s 1 ar f Hea item other		'		20b. Place of Disp	osition (Name of	D	ate	20c. Location -	City or To	wn, State
23. Part L. Enter the phrases or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory areat. Principles of the phrases of complications and cause of death. Do not enter the mode of dying, such as cardiac or respiratory areat. Principles of the phrases of complications and cause of death. Do not enter the mode of dying, such as cardiac or respiratory areat. Principles of the phrases of complications and cause of death. Do not enter the mode of dying, such as cardiac or respiratory areat. Principles of the phrases of complications are caused the death. Do not enter the mode of dying, such as cardiac or respiratory areat. Principles of the phrases of complications are caused the death. Do not enter the mode of dying, such as cardiac or respiratory areat. Principles of the phrases of complications are caused the death. Do not enter the mode of dying, such as cardiac or respiratory areat. Principles of the phrases of complications are caused on the death. Do not enter the mode of dying, such as cardiac or respiratory areat. Principles of the phrases of complications are caused on the death. Do not enter the mode of dying, such as cardiac or respiratory areat. Principles of the phrases of complications are caused on the death. Do not enter the mode of dying, such as cardiac or respiratory areat. Principles of the phrases of the phrases of cause of death? Principles of the phrases of cause of death. Principles of the phrases of cause of death? Principles of the phrases of cause of death? Principles of the phrases of cause of death? Principles of the phrases of cause of death? Principles of the phrases of cause of death? Principles of the phrases of cause of death? Principles of the phrases of cause of death? Principles of the phrases of cause of death? Principles of the phrases of the phrases of the phrases of the phrases of the phrases of the phrases of the phrases of the phrases of the phrases of the phrases of the phrases of the phrases of the phrase	E C	Page nent o int: If iry or			emoval from State				7–06	Hagers	town	Maryland
Approximate finite property of the property of	Balti	permit. Depurtu Importe any inju		21. Si nature of Funeral Service License	XIII							
Part Dies Clause Claus			1	23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused						Ť	Approximate Interval Between
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The control of the		at the by th	hys	9 🗆 Unknown		1			1			
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29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 34-6	OU	nding th. : Afte	tion	1 Pending	(Month, Day	Year) Injury				,,,,,		
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 34-6	Divisi	l or Atten after dea Director	ertifica	3 Suicide 6 Could not be	28e. Place of Inju building, etc	ry - At home, farm, st . (Specify)	reet, factory, office	2			er or Rura	l Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 314 Eart Antie tram Struct. Fulle 200. Higgs strwn M 37740		Hospite 24 hours Funerel etely filled		(Check only 2 Medical Examin	ner: On the basis of	examination and/or in						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 314 Eart Antie tram Struct. Fulle 200. Higgs strwn M 37740		To the Within To the	Me				29c. License	number	25	9d. Date signer	d (Month, I	Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 314 England Am Tile tam STrult. Full 200. Hagen Stown M. 27740		, , , , , ,		> SAMUEL CLAR	W MD		1)36	655		JAN "	4;2	006
04 Deal Glad (Manth Day Voor) 20 Degistrade Cioneture				30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type	Print)	40. 1.		100	211	
	SH	-6					c wo. 1	ingenstu	NN I	M.	140	

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Registrar

BETTY CULLAMS OLIVER

BENITO NARVAEZ 06-00275

Funeral

Director

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Department of Health and Mental Hygies
Important: if Item 27 is marked other ti
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Physician

/Medical

Examiner

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within 24 hours after of To the Funeral Direct completely filled in by

director,

filled in by the

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

To the Hospital or Attending Physician:

The Medical Exa

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

Amend unpend item#1,23a,27,pen/E,8555,5/5/06 IT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Physician Benito Pecina Narvaez January 11, 2006 7:02 a. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery County If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 21 Yrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Mar. 25, 1984 9. Birthplace (State or Foreign Months Days Hours 1**⊠** M 2□ F none Mexico Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Gaithersburg 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 429 Muddy Branch Road Mexico Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married 1 X Yes 2 ☐ No þ Specify: White 3 Widowed 4 Divorced Mexican Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Drywall Finisher Construction 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Santiago Narvaez Somona Pecina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
429 Muddy Branch Road Gaithersburg, Md20877 19a. Informant's Name/Relationship (Type, Print) Eliadio Narvaez/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State El Juajal, Guadal-Cemeterio Municipal1/21/06 4 Donation 5 Other (Specify) cazar, Mexico 21. Signature Varietal Service Licens PHILIP D.RINALDI FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 9241 Columbia Blvd.Silver Spring,Md Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac arrhythmia Due to (or as a consequence of): Sequentially list conditions, it any, leading to initial diacase. Enter Underlying Cause (Disease or injury that initiated events Dualto (or as a consequence of) Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

124 Yes 2 \square No 24a. Was an autopsy performed? f**y** Yes 2 No 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1X Yes 2 🗆 No 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**CXMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 12, 2006 OCME Jashe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 Greenbera Taska Z M.D

State Registrar

31. Date filed (Month, Day, Year) **JAN 17**

32 Registrar's Signature 2006

			1 - For State Registrar	State of Mary		artment of H		nd Mer	_	ene 0 0 6	01269
			1. Decedent's Name (First, Middle, Last)						Date of Death	1	3. Time of Death
	Physici /Medi		Leola Wilmith	n Payne				Jai	Month NUALY	11 2000	1150 M
	Examir		4a. Facility Name (If not institution, give str		,	4b. City, Town, or			7	4c. County of D	eath
			The Memorial	HUSPITAL		Eas	500			Tale	bot
	Funeral Director		5. Social Security Number 6. Sex 1 Number 1 Number 6. Sex 1 Number	7. Age (In	n yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. De	Date of Birth (Month, Day, C. 17,	Year)	Birthplace (State or Foreign Country) Shington, DC
	p ,		Usual Residence of Decedent							1110	
	anyla shov	_	10a. State 10b. County	10	c. City, Town or Lo						10d. Inside City Limits
	Ba-f	ecto	MD Talbot			East	on	J			1- XYes 2 No
	with t	吉	10e. Street and Number			10f. Zip Code	0.4		10	g. Citizen of What	
	eath	erai	501 Dutchman's I	ane Was Decedent Ever	rin IIS 123	216		i=2 (C===it)	W N	United	
	ter d	Funeral Director	11. Marital Status 12 1 ☐ Never Married 2 ☐ Married	Armed Forces?	13.1	Vas Decedent of Hi f Yes, specify Cuba	n, Mexican,	Puerto Rica	res or No- in, etc.)	Black, W	merican Indian, hite, etc.
036	urs a	by	3√ Widowed 4 Divorced	If Yes, Give X Year or Dates:		I□Yes 2∏ No	Specify:			Specify:	White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-1 show ont, the Medical Examination to Indiffed at	Completed	15. Decedent's Educa	ion	16a. Deced	lent's Usual Occupa	ation	-f -di-	1	6b. Kind of Busine	ss/Industry
21	thin 7	npie	(Specify only highest grade of Elementary/Secondary (0·12)	College (1-4or 5+)		kind of work done of OO NOT use retired,	uring most	of working			
	filed withi Hygiene. other than	Son	7		Home	emaker				Own Hom	1e
Maryland	be fil ntal H od ott	Be	17. Father's Name (First, Middle, Last)							laiden Sumame)	
3	should be nd Mental marked o umatic eve	င္	Thomas Leonard						ie Sc		
Ma	d 2 sho		19a. Informant's Name/Relationship (Type Shirley Moreland			g Address <i>(Str</i> eet a				-	GA 30566
a)	s 1 and 2 should be filed within 72 hours after death with the Marylar I Health and Mental Hygiene. I then the marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Example or must be rediffed at		20a. Method of Disposition	·	20b. Place of Dispo	sition (Name of	1	Date		Oc. Location - City	
ΘĽ	Pages nent of int: If it		1 XBurial 2 ☐ Cremation 3 ☐ Ren 3 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	-	natory`or other place y- Cemeter	, (1/14/			
Baltimore,	그는모금		21. Signature of Funeral Service Licensee							Cokesbui	
ä	permi Depa Impo any ir		Millar 7- 9	kno	21	o N. Mair	1 St.,	rede:	raisbu	rg, MD 21	Home, P.A. 632
П			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	cause on each line.		er the mode of dying	g, such as c	ardiac or res	spiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	7	10515						Oriset and Death
	/Medical Examiner		Todaming in addition	Due to (or as a op	inary t	act m	IPIL	S1 10			
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			U					
o`	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Exa	resulting in death) Last	Due to (or as a co	onsequence of);						
68760,	ate be hysici the bu	edicai	d								
	e as	Mec	IF FEMALE:								1
Вох	eath certiff attending for use as	ian/	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of policy 1 Live birth 2	Fetal death 3	Ectopic pregnancy				23d. Date of o	delivery Day Year
o.	at the de by the a stached	Physician/M	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	e or death 5	Other (specify)					
<u>α</u>	that led by deta		Part II. Other significant conditions contril	outing to death but no	ot resulting in the un	derlying cause give	n in Part I.		23e. Did toba	acco use contribute	to the cause of death?
of Vital Records,	quires n sign ald be	ed by	Acute Rend	cilul					1 🗌 Yes	2 No 3 🗆	Probably 4 DUnknown
00	aw requir s been si 2 should b	Completed	dehydration						24a. Was an	24b. Were	autopsy findings available
R	The lav	шо						_	autopsy perform 1 ☐ Yes 2	ed? death	o completion of cause of ? es 2□ No
ital		Bec	25. Was case referred to medical				26. Place of		eck only one		63 Z NO
<u>_</u>	di is	2	examiner? 1 ☑ Yes 2 ☐ No Hos	pital: 1 npatient	2 ER/Outpatient	3□ DOA Othe	r: 4 ☐ Nurs	sing Home	5 Residen	ice 6 Other (Sp	pecify)
	ding Ph h. After th funeral	ou:	27. Manner of Death 1 Manner of Death 5 ☐ Pending	28a. Date of Injury (Month, Day Ye.	ar) 28b. Time of Injury	28c. Injury Work	at ?	28d.	Describe how	v injury occurred	
Sio	tendi leath. tor; A the fu	cati	2 Accident investigation				'es 2 □ N				
Division	ial or Attendi s after death. al Director; A ad in by the fu	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre Specify)	et, factory, office			ocation (Stre		Rural Route Number,
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director; Atter to completely filled in by the funera	edicai C	29a. Certifier 1 Certifying Physici (Check only one)	en: To the best of my On the basis of exa and manner stated.	amınation and/or inv	occurred at the time estigation, in my op	e, date and inion, death	place, and o occurred at	due to the cau the time, dat	use(s) and manner e and place, and d	as stated. ue to the cause(s)
	To tl within To tr comp	Me	29b. Signature and title of certifier	7 11 1-		29c. License			290	d. Date signed (Mo	
)				M. LO	Eura J	m 0	5548	34		/	12-06
			30. Name and address of person who comp					-11			
	Sta	to	H. Laura Jin, 219 31. Date filed (Month, Day, Year)	S. Wash	lington Signature	St. Eas	ton,	MD 2	1601		
	Registr		31. Date filed (Month, Day, Year)	32 Registrar's	Jr Asi	and s					

Physician /Medical Examiner burial-transit The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital

To the Hospital or Attending Physician:

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To the Funeral Director: Att

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Physician

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Examiner

10a. State

Funeral

Director

or 28a-f show

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permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23% eny injury or other traumatic event, the Medical Examiner must

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

Director

Completed by Funeral

Be

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with the Maryland

Completed by Be ဥ

Physician/Medical Examiner Certification:

25. Was case referred to medical examiner?

IF FEMALE 1 ☐ Yes 2 ☐ No 9 Unknown

23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Day Year

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? Yes 28 No 1 Yes 26. Place of Death (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 2 No

1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident

3 Suicide

29a. Certifier

4 T Homicide

5 Pending investigation 6 Could not be determined

Hospital: 1 | Inpatient 28a. Date of Injury (Month, Day Yeer) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D-0053720

29d. Date signed (Month, Day, Year) 01/04/2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100, S. Atward Rd, #100, Belowir. KeD

pearcel 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

			1- State of Ma		artment of Health and rtificate of Death	, ,							
	Physic		Decedent's Name (First, Middle, Last) MARSHALL E. PARKE		imouto or Boatin	2. Date of Death Month Jahvery	Day Year 8:05 PM						
	/Medi Examii		4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPIT.	A L	4b. City, Town, or Location of De HAGERSTOWN	-	4c. County of Death WASHINGTON						
100	Funeral Director		5. Social Security Number 6. Sex 7. Ag 232-32-7416 1 M 2 F	e (In yrs. last birthday) 74 Yrs.	If Under 1 Year If Under 24 H Months Days Hours M		ar) 9. Birthplace (State or Foreign Country) WEST VIRGINIA						
	Maryland I-f show	tor	10a. State 10b. County WV BERKELEY	10c. City, Town or Lo	rcation RTINSBURG		10d. Inside City Limits 1 XX Yes 2 □ No						
	th with the 23a or 28s	al Direc	10e. Street and Number 503 BACHMAN LANE		10f. Zip Code 25401	10g.	Citizen of What Country?						
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, if a Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 X Yes 2 1 Yes, Give Year or Dates:	No I	Was Decedent of Hispanic Origin? f Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 ☑ to Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race · American Indian, Black, White, etc. Specify: WHITE						
21215-0036	Jwithin 72 ho piene. r than "natur r bedical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5)	(Give	dent's Usual Occupation kind of work done during most of v DO NOT use retired) GHT ENGINEER	vorking 16b	Kind of Business/Industry / AIR NATIONAL GUARD						
Maryland 2	could be filed Mental Hyg narked othe	To Be C	17. Father's Name (First, Middle, Last) HARRY CARL PARKER			ETHEL ANDE	RSON						
	1 and 2 st Health and em 27 la n ther traun		19a. Informant's Name/Relationship (Type, Print) ROBERT C. PARKER/SON 20a. Method of Disposition		BACHMAN LANE, M	ARTINSBURG,	WV 25401						
Baltimore,	it. Pages intment of l ortent: if its njury or o		1 Survival 2 Tremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	PLEASANT V GARD	TEW MEMORY (6, 2	NUARY 2006	MARTINSBURG, WV						
Ba	permi Depa Impo		23a. Part 1. Enter the disease, or complications that caused		BROWN FONERAL HOME,	MARTINSBURG.	, WV 25402						
*	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	adcel	(u Fara an	ac of respiratory arrest,	Approximate Interval Between Onset and Death						
),	Examiner and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a consequence of): THEE a consequence of): volutes a consequence of):	repare CIRI	(GC (IVE	2)						
.O. Box 68760,	death certificate e attending phy: d for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year						
rds, P	quires tha en signed I ould be det	by	Part II. Other significant conditions contributing to death by	ut not resulting in the ur	nderlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown						
Vital Records,	icien: The law requires that the certificate has been signed by the ector, page 2 should be detache	Completed	esquéged vovies 24a. Was an autopor prior l'autopor performed? 1 Pres 2 No 150										
f Vit	dir y	To Be	25. Wa as referred edical examiner? 1 Yes 2 100 Hospital: Inpatie	nt 2 ER/Outpatien	Othor	eath (Check only one) Home 5 Residence	6 □Other (Specify)						
Division of	ing After une	Certification:	27. Manner eath 1 in atural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	y 28b. Time of (Year) Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in							
Divi			4 Homicide determine 286. Place of Inju-			City or Town, Sta							
	T 4 T 0	edical	29a. Certifier 1 ★ Certifying Physician: To the best of (Check only one) 2 ★ Medical Examiner: On the basis of and manner sta	examination and/or inv	occurred at the time, date and pla- estigation, in my opinion, death oc-	ce, and due to the cause curred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)						
	To the within 2 To the complet	W	29b. Signature and title of certifier										
			30. Name and address of person who completed cause of de	eath (Item 23a) (Type, F	HUO b(()		7-06 21743 Hogestour, MD						
51	1-2+1		Al encisco A. Denie 31. Date filed (Month, Day, Year) 32. Registra	(/ D 3	251 E- Ant	etam SI.	Hosesian MD						
	Sta Registr		JAN 0 5 2006	A 4	cest								

RONALD M. PLUMMER 06-0019 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Inpend item#23a,PII,27,pen/E,6851,1/21/06 IT

		Unpend item#2 1 - For State Registrar	State of M	farylah		artmen tificat			and M		giene Reg. No.	06	012	73
Physicia	an	Decedent's Name (First, Middle, Last) RONALD MARTIN PL								2. Date of Dea Month JANUAR	Day	2006	3. Time of E 2:02P	
/Medic Examin		4a. Facility Name (If not institution, give a 211 E. CAMPUS AVE	street and number	7)			Town, or	Location o	of Death	OTHVOTAK		ty of Death	2.021	•
Funeral Director			M 2□F 7. A		last birthday) 36 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth Month, Day MAY II,	1969	9. Birthp Cour	place (State or htry) MD	Foreig
death with the Maryland ms 23a or 28a-1 ehow	tor	Usual Residence of Decedent 10a. State 10b. County MD KENT			y, Town or Lo							1	0d. Inside City 1 [X¥es	
h with the	ai Dire	10e. Street and Number 211 E. CAMPUS AVE				10f. Zip	Code 216	20			10g. Citizen o	f What Cour	ntry?	
urs after deal	by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ሺ Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates	? No		Was Deced 1 Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		ace - Americ lack, White, cify: WHI	etc.	
permit. Pages 1 and 2 should be ilied within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If them 27 is marked other than "naturel; or Items 28a or 28a-f show eny injury or other traumatic event, the Modical Examinar must be notified at once.	Completed by Funeral Director	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+	5+)	life. I	tent's Usua kind of wor DO NOT us LAWYE	rk done d se retired,	urina most	of workir	99	16b. Kind of	Business/In	dustry	
uld be filed Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, Last) RONALD LEE PLUMME	2							(First, Middle, SPARKS		ame)		
and 2 sho salth and h n 27 le ma ar trauma		19a. Informant's Name/Relationship (Ty SHARON KENDALL/MO								Route Numbe K HALL,			Code)	
Pages 1 ment of He ant: If Iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	. 0		natory`or o IAPEL	CEM.	ETERY	01/	ate 07/2005		HALL,	MD	
permit. Departimporti eny inj		21. Signature of Funeral Service License Buck J	Speler	0	22	Name and ELLO	d Addres WS, I PEER	s of Facility HELFE ROAD	NBEII	N & NEW ESTERTO	NAM FU WN, MD	NERAL 2162(HOME,	Ρ.
ate be hysicie the bu	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a conseq	ивпсе об;	scular	Dise	ase					Onset and De	
The law requires that the death certificate has been signed by the attending page 2 should be deteched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcom 1 Live birth 4 Pregnant a 9 Unknown	2 Feta	ldeath 3□	Ectopic pro					1	ate of delive	ory Day Ye	ar
quires that n signed b uld be dete	ρ	Part II. Other significant conditions con Cocaine use, Obesity	tributing to death	but not res	ulting in the ur	nderlying c	ause give	n in Part I.			bacco use co		e cause of dea	
stcian: The law requir certificete has been si irector, page 2 should l	Completed									24a. Was a autop: perfor	sy	. Were autoprior to cordeath?	psy findings av npletion of cau	railabi
F SEP	ion; To Be	27. Manner of Death 1 Natural 5 Pending	ospital: 1 Inpat 28a. Date of Inj (Month, D		ER/Outpatien 28b. Time of Injury	2	Bc. Injury Work	r: 4□ Nur at ?	rsing Horr	Check only or ne 5 Reside 8d. Describe h	ence 6 🛣) SCENE	
to the Hospital or Atlending within 24 hours after death. To the Funeral Director: Atlet completely filled in by the fune.	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir building, e	njury - At ho tc. (Specif	ome, farm, stro	M eet, factory		'es 2 □ N		8f. Location (S City or Tow	treet and Nun n, State)	nber or Rura	l Route Numbe	э <i>г</i> ,
to the Hospital or within 24 hours afte To the Funeral Dirt completely filled in the	Medicai (29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☑ Medical Examin	icien: To the bes er: On the basis and manner s	of examina	wledge, death tion and/or inv	occurred a restigation,	at the tim in my op	e, date and inion, deat	place, a	nd due to the c d at the time, d	ause(s) and n late and place	nanner as st , and due to	ated. the cause(s)	
within To th	Ň	29b. Signature and title of certifier	Glla	nv	ud		O.C.	number M.E.			29d. Date sign			
Stat	te	30. Name and address of person who co	ALLX	death (Item	ld	Print)	PENI	I STRI	EET_H	BALTIMO	RE MARY	ZLAND	21201	

			1 - For State Ragistrar	State of Marylan	d / Depa		lealth and M	Mental Hyg	_	
	Physici		1. Decedent's Name (First, Middle, Last, Rufus Coolridge					2. Date of Deat January	h	3. Time of Death 4:45P. M
1	/Medi Examir		4a. Facility Name (If not institution, give Laurel Regional Ho	_		4b. City, Town, o Laure	r Location of Death $oldsymbol{1}$		4c. County of	
· ,	Funeral Director		5. Social Security Number 6. Security Number 13-44-4787	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Sept. 13	, 1945 V	Birthplace (State or Foreign Country)
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge		, Town or Lo lege F					10d. Inside City Limits 12 Yes 2 No
	h with the 23a or 284 let be not	Funeral Director	10e. Street and Number 4905 Huron Street			10f. Zip Code	20740	11	og Citizen of What United S	at Country? tates
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show mithortant: if Item 27 is marked other than "natural", or items 23s or 28s-f show mithortant: it lies a continue that it is notified at an once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H 1 Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		American Indian, White, etc. White
21215-0036	ad within 72 hargiene. or than "natu", the Medical	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i> College (1-4or 5+)	16a. Deced (Give life. L Drive		ation during most of work d)	ring	16b. Kind of Busin Freestat	ess/Industry e Electric
Maryland	2 should be filed with and Mental Hygiene. Is marked other than aumatic avant, Itte	To Be (17 Father's Name (First, Middle, Last) RUTUS C. PULTZ,	Sr.			Beverly		fflett	
	Health and the tem 27 is my tem 27 is my other traum		19a. Informant's Name/Relationship (Ty Janet L. Pultz -wi	lfe			and Number or Rur reet Coll	al Route Number, .ege Park	City or Town, Sta , Maryla	re, <i>Zip Code)</i> ind 20740
Baltimore,	permit. Pages 1 Department of H Important: If Ited any injury or ott		20a. Method of Disposition 143 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State $\stackrel{\text{20b. PI}}{\text{ce}}$	ace of Dispo emetery, cren Hill	sition (Name of natory or other place Cemetery	1/6/2		aurel, M	
Balt	Dermit. Depart Import any inj		21. Signature of Funeral Service License Donald V, B	Jua !!	44	-00 Powde	Borgwardt r Mill Ro	ad Belts	ville.Ma	A ryland 20705
*46	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	End Stage	Chron	er the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
Agent of	Examiner	34		Due to (or as a consequence Alcohol L. Due to (or as a consequence Due to (or as a co	iver (Cirrhosis				
1,092	death certificate be executed e attending physician and of for use as the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						
x 687	# × #		IF FEMALE:	Sc. If yes, outcome of pregnar						
P.O. Box	at the death certifica by the attending ph tached for use as th	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3□ ath 5□	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
Ś	equires that en signed ould be de	Ď	Part II. Other significant conditions cor Diabetes Mellitu		lting in the un	derlying cause give	en in Part I.		acco use contribut	te to the cause of death? Probably 4 Zunknown
		e Completed	25. Was case referred to medical	707			- m//	24a. Was an autopsy perform	ed? prior deat X No 1 □	e autopsy findings available to completion of cause of h? Yes 2 No
ι of Vii	Phys this rat dii	To B	examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death	1	R/Outpatient 28b. Time of Injury	3 DOA Othe	er: 4 🗆 Nursing Ho	n <i>Check only one</i> me 5 ☐ Resider 28d. Describe hov	nce 6 Other (5	Specify)
Division	or Attending ter death. Irsctor: After by the fune	ertification:	1 ANatural 5 Pending investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	M 1 []	Yes 2□No	28f. Location (Stre City or Town,	eet and Number o	r Rural Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: 4 completely filled in by the f	edical Cer	(enternal) Z Intodicol Examini	sician: To the best of my knowner: On the basis of examination	rledge, death	occurred at the timestigation, in my or	ne, date and place,	and due to the car	ISO(a) and man-	r as stated.
	To the within To the comp	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number		d. Date signed (M	
	(7)		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, F	Print)	0100	to ins	(1	altun oran
	Sta Registr	_	31. Date filed (Month, Day, Year) JAN 0 4 200	32 Registrar's Signatu	Ire Apr	we por	my suc	12 (05	Creent	veltMD 20770

			1 - For State of Maryland /	Department of Health and Mental Hygiene Certificate of Death	CUU5 1112/5
		4	Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
PL.	Physici /Medic		CALVERT RICHARD POSEY,	SR. JANUARY S	$\frac{1}{2}$, $\frac{1}{2}$
	Examin		4a. Facility Name (If not institution, give street and number)		c. County of Death
	Funeral Director		SOUTHERN MARYLAND HOSPITAL 5. Social Security Number 6. Sex 219-12-2979 7. Age (In yrs. iast b)	CLINTON PR inthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, FEB. 18, 1	RINCE GEORGE'S 9. Birthplace (State or Foreign Country) 1924 MARYLAND
	pue *	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Location	10d. Inside City Limits
	Maryli f •ho	5		EMOY	1 Yes 2 No
	r 28a-	rec	10e. Street and Number		itizen of What Country?
	th with	aiD	5345 TURKEY TAYAC PLACE	20662	U.S.A.
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: if item 27 is marked other then "neturel", or items 23a or 28a-f show important: if item 27 is marked other then "heldrel", or items 23a or 28a-f show any injury or other treumatic event, the Medical Excilinat must be notified at angle.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No tt Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X No Specify:	14. Race - American Indian, Black, White, etc. Specify: WHITE
215-0036	nin 72 ho n. "netu Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cottege (1-4or 5+)	(Give kind of work done during most of working	Kind of Business/Industry IARLES COUNTY
2	filed witl Hygiene other the	Com	12 4	NATURALIST BD	. OF EDUCATION
Maryland	tould be fill Mental Hy narked oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maider	
2	should nd Men marke umatic	2	TIMOTHY RICHARD POSEY 19a. Informant's Name/Relationship (Type, Print) 15	EDITH FLORENCE The Mailing Address (Street and Number or Rural Route Number, City	
Na Ba	nd 2 s alth ar 27 to r treu			825 TAYLOES NECK RD., NANJE	
Je,	of Health of Health item 27 i		20a. Method of Disposition 20b. Place		ocation - City or Town, State
Ë	Page ment of ant: If ury or		I Dutial 2 Microtifation 2 Divertification 2 rate	TIAN CREMATORY 01-12-06 AL	EXANDRIA, VA
Baltimore,	permit. Depertrimports eny inje		21. Signature of Fuperal Service Licensee M00479	22. Name and Address of Facility RAYMOND FUNERAL SERVICE,	
	40200		23a. Part1. Enter the disease, or complications hat caused the death. Do	TA DIATA MADVIAND 2064	
	Physician		Immediate Cause (Final	_	Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a	601):2	Challanow
	Examiner		Sequentially list conditions. b. Mu	Stiph mylown	Cultonon
/	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	e of):	
	icate be executed physicien and s the burial-transit	хап	that initiated events c. resulting in death) Last Due to (or as a consequence	e of):	
8760,	s be e	calE	(d		
9	tificat ng phy as th				
.O. Box	n requires that the death certifica been signed by the attending ph should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
ds, P	ires tha signed l	by	Part II. Other significant conditions contributing to death but not resulting		use contribute to the cause of death?
Records,	> 45	etec			
	ding Physician: The law n. n. Alter this certificete has b funeral director, page 2 st	Completed		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
of Vital	ian: T	Be C	25. Was case referred to medicat	26. Ptace of Death (Check only one)	1 Yes 2 No
> >	Physician: this certific rat director,	ToE		Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence	6 □Other (Specify)
S C	ling P		1 Natural 5 Pending (Month, Day Year)	Time of Injury 28c. Injury at Work? 28d. Describe how inju	ury occurred
Division	Attending r death.	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home,	M 1 Yes 2 No	and Number or Rural Route Number,
Θį	afor A after t Dire d in by	ertil	4 Homicide determined building, etc. (Specify)	City or Town, Stat	
	To the Hospital or Atlendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Certification:	29a. Certifier Check onto 2 Medical Exeminer: On the basis of examination a one) One) One) One)	ge, death occurred at the time, date and place, and due to the cause(sand/or investigation, in my opinion, death occurred at the time, date an	s) and manner as stated. nd place, and due to the cause(s)
	To t To t	Σ	29b. Signature and title of captier		ate signed (Month. Day, Year)
			30. Name and address of person in completed cause of death (Item 23a		may 10,06
_	8		1 1111 00 10	(Type, Print) ARASIO YAZDANI, M.D.	
1	Sta	ite	31. Date filed (Mont), Day, Year) 32. Registrar's Signature	1	
	Regist		I SHARKE K ZIIIIL KEA DE AN A	MARL!	

			1 - For State Registrar	State of Ma	arylan		artmen rtificate				ental Hy	giene Reg. No	.000	01276
	Physici /Medio	al	1. Decedent's Name (First, Middle, L Alfred		Ŧ	Palvi	nbo		16	-1 011	2. Date of De Month Januar	y 9	2001	6 1800 PM
	Examir Funeral	ier	,	ns Hospital	(In yrs. i	ast birthday)	Bal	timo 1 Year	If Under	ety 24 Hrs.	8. Date of Bir	rth	. County of De	irthplace (State or Foreign
	Director		099-14-8563 Usual Residence of Decedent 10a. State 10b. County	XDM 2□F	83	Yrs.	Months	Days	Hours	Min.	Feb. 10	6, 1	922 Nev	V York
	the Maryla 28a-f shov pliffed at	ector	MD Harfo 10e. Street and Number	ord		y, Town or Lo	n					10 0		10d. Inside City Limits 1 ⊠Yes 2 □ No
	3a or	Dig	716 Cambridge Av	<i>r</i> enue			10f. Zip	001					izen of What (country?
200	J within 72 hours after death with the Maryland Jiene. r than "natural", or Itams 23a or 28a-f show the Mudical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces?	О		Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:		cify Yes or No Rican, etc.)			
2.13-0030	n "na"	Completed	15. Decedent's (Specify only highest g	Education		(Give	dent's Usua kind of wor DO NOT us	k done d	luring mos	t of workin	g		ind of Busines	
ומנומ ל	be filed stal Hyg od othe event,	To Be Cor	12 17. Father's Name (First, Middle, Las Anthony Palumbo	44		0.5.	нтшу				(First, Middle,	, Maiden		
Mary	nd 2 should alth and 27 ls m	-	19a. Informant's Name/Relationship Marie V. Palumbo				ng Address Cambr						or Town, State, Marylar	
Dalilli II Ore,	S + = 0		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		i	lace of Dispo emetery, crer A. Fe				/13/0)6		cation - City o	
Dair	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	ensee	11	27	Name and Tarrin Aberue	Addres 19-C een,	s of Facilit argo Maly	Funer Tand	ral Hor	ne,] -33	P.A.	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. Acute Due to (or as a	My	eloger		1-			respiratory a	rrest,		Approximate Interval Between Onset and Death
,0070	death certificate be execured e attending physician and of for use as the burial-transit	ai Exan iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a										
	tificate ig phy: as the	ledicai		a	,									Ĺ
.O. DO	the hed	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 Fetal	death 3	Ectopic pre Other (spe						23d. Date of d Month	elivery Day Year
ecolds, r.	w requires that the been signed by should be detac	by	Part II. Other significant conditions	contributing to death bu	t not resu	Ilting in the ui	nderlying ca	use give	n in Part I.		23e. Did to	4	1	to the cause of death?
	The law ate has b page 2 sh	Completed								·····	24a. Was autop perio 1 🗆 Yes		prior to death?	
VII		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt '2 🗀 8	ER/Outpatien	t 3 🗆 DO/	Othe			Check on o		6 □Other (Sp	onitu)
=	ing After une	ertification: T	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day	,	28b. Time of Injury		lc. Injury Work		21	Bd. Describe h			<i>өспу)</i>
Dision	To the Hospital or Attend within 24 hours after death To the Funeral Director: . completely filled in by the f	O	3 Suicide 6 Could not 4 Homicide determine	d 288. Place of Injui	(Specify	·) 					City or Tov	vn, State)	Rural Route Number,
1	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	ledical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	Physician: To the best of aminer: On the basis of and manner state	examınat	wledge, death ion and/or inv	occurred a restigation,	t the time in my op	e, date and inion, deat	d place, ar th occurre	nd due to the	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	To 1 To 1 COM	W	29b. Signature and title of certifier	er, MI	>			License D62		8				th, Day, Year)
	Sta	ite	30. Name and address of pers Nina Wagner, Mi 31. Date filed (Mortin, Day, Year)	o completed cause of de O JOHNS Hop 32. Registral	kins Kins rs-Signat	23a) (Type, 105011	Print)	O NO	rthW	olfe s	itreet B	Baltin	nore, M	2006 D 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiefie 0.0.

			1 - State Registrar	State of Maryland / L	Certificate of Death		/gieneUUb Reg. No.	01277
	Physici		1. Decedent's Name (First, Middle, Las ELWOOD ISAAC	•		2. Date of De Month	Pay 2006	3. Time of Death 6:00 P M
	/Medic Examin		4a. Facility Name (If not institution, give GARRETT COUNT	ry MEM'L HOSP.	4b. City, Town, or Location OAKLAND	of Death	4c. County of Dea	oth CT
	Funeral Director		5. Social Security Number 235-34-6209 Usual Residence of Decedent		hday) If Under 1 Year If Under 1 Year Months Days Hours	Min. 8. Date of Bi	rth 1926 BEN	thplace (State or Foreign NBUSH, WV
	e Maryland	ctor	10a. State 10b. County TUCKER	10c. City, Town				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	th with th	al Dire	PO BOX 436		10f. Zip Code 26292		10g. Citizen of What C	ountry?
900	d within 72 hours after death with the Maryland jiene. r than "neturel", or items 23a or 28a-f show the Medical Examiner must be redified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Agged Forces? 1 ঐYes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica			erican Indian, te, etc. JHITE
1215-0	within 72 ho sne. than "netu	Completed	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12)	ucation de completed) 16a. College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during mo life. DD NOT use retired) COAL MINER	st of working	16b. Kind of Business	/Industry
Maryland 21215-0036	be filed ttal Hygi d other event.	To Be Co	17. Father's Name (First, Middle, Last) ISAAC OGDEN PA	AUGH	18. Moth	ner's Name <i>(First, Middle</i> LTH LENORA	a, Maiden Sumame)	
	12 s h ar 7 ls treu		19a. Informant's Name/Relationship (7 WANDA PAUGH /		Mailing Address (Street and Numb BOX 436 THOM	MAS, WV 2	per, City or Town, State, 26292	Zip Code)
Baltimore,	permit. Pages 1 and Department of Healt Importent: If item 2 eny injury or other once.		20a. Method of Disposition 1	Removal from State	Disposition (Name of y, crematory or other place) HILL CEMETER)	Date 7 1-6-06	20c. Location - City or THOMAS,	•
Balt	permit. Departr Import. eny inj		21. Signature of Huneral Service Licenta	11/2/6	PO BOX 186	RAL HOME DAVIS WV	26260	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or companies shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	aDue/to (or as a consequence of	nea	s cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	ocuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence of	rf):			
68760,	tificate be executed g physician and as the burial-transit	Medical Ex	resulting in death) Last	Due to (or as a consequence of d	f):			
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	livery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions on Mentiopshi		the underlying cause given in Part	1. 23e. Did t	tobacco use contribute to	o the cause of death?
Il Records,		Completed						utopsy findings available completion of cause of
Vital	Physiclen: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐Inpatient 2 ☐ ER/Out	Other	e of Death (Check only oursing Home 5 Resi		city)
on of	ding Ph h. After thi funeral	lon: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Ti	ime of 28c. Injury at jury Work?	28d. Describe	how injury occurred	ony
Division	Atten deal ctor: y the	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		M 1 ☐ Yes 2 ☐ m, street, factory, office		Street and Number or Ri wn, State)	ural Route Number,
J	To the Hospitel or within 24 hours after To the Funeral Director Completely filled in b	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my knowledge, iner: On the basis of examination and and manner stated.	death occurred at the time, date at Vor investigation, in my opinion, de	nd place, and due to the ath occurred at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
1	To th To th comp	Š	29b. Signature and title of certifier	14 /1/10	29c. License number		29d. Date signed (Mont	
•			30. Name and address of person who d	completed cause of death (Item 23a)	Type, Print)	Oaklara	1/2/00	
	Sta	to	31. Date filed (Month, Day, Year)	mp 3UN, Fount 32. Registrar's Signature	4 Sty Suitely	Oaklara	/ mp 21	550
	Registr	- 2	JAN 1 8 2006	10	selv			

		•	For State Registrar		State o	of Maryla	and / Dep <i>Ce</i>	artmen <i>rtificat</i>					gien Reg. N	2111	16	01278
			1. Decedent's Name (First, M	iddle, Las	t)							2. Date of De Month		ay	Year	3. Time of Death
J.	Physici /Medic		Mark Pl	ummei	-							Januar	у 1 ⁷	ī, 20	006	11:15 А м
	Examin		4a. Facility Name (If not instit	ution, give	street and nu	mber)		4b. City,	Town, or	Location	of Death		4	c. County	of Death	+
			Harford Me	moria	al Hosp	ital		Hav	re d	e Gra	ace			На	rfor	rd.
3	Funeral Director		5. Social Security Number 213–52–6432	6. Se	x M 2□F	7. Age (In y 58	rs. last birthday, Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Aug. 2	th ly, Yea,		9. Birth	place (State or Foreign intry) Yland
			Usual Residence of Deceden	t												
	how		10a. State 10b. Co	inty		10c.	City, Town or L	ocation								10d. Inside City Limits
	e Ma	Director	MD H	arfor	rd	I	Aberdeer									1 ☐ Yes 2 No
٢	1 th	ire	10e. Street and Number					10f. Zip	Code				10g. C	Citizen of V	What Cou	intry?
	15 wi		607 Beards	Hill	Road			2	1001				Ţ	J.S.A		
	dea	Funeral	11. Marital Status		12. Was Dec Armed Fo	edent Ever in	n U.S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.))-		e - Amer	ican Indian,
36	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Exeminer must be notilled at	by Fu	1 Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo	37	1 ☐ Yes If Yes, Gi Year or D	2 [] No ve		1 🗆 Yes		Specify:	.,			1	Whi	
8	"natural", or	pa		dent's Ed			16a, Dece	dent's Usua	al Occupa	ıtion			16b.	Kind of Bu		
15	C 9	Completed	(Specify only hi	ghest grad	de completed)		(Give	kind of wo.	rk done a	uring mos	t of work	ing				
12	within iene. then	Ē	Elementary/Secondary (0-12	2)	College (1-4or 5+)	Jan	itor					.Ta	nito	ral	
9	The Th		17. Father's Name (First, Mid	dle, Last)						18. Mothe	er's Name	e (First, Middle				
an	a a a e	To Be	Wiley Mit	chell	Plumm	er				Pear	l Ja	nice Bu	irch	nette		
2	d 2 should th and Men 7 Is marke traumatic	-	19a. Informant's Name/Relat				19b. Mail	ng Address	(Street a			al Route Numb			_	ip Code)
S			Eric Stephen	Plum	mer (B	rother		Hurle				Air, Ma			210	
e,	s 1 and 2 of Heelth a Item 27 Is r other trau		20a. Method of Disposition		•	20	b. Place of Disp	osition (Nar	ne of	1		Date	_			own, State
Baltimore, Maryland 21215-0036	Peges tment of tant: if I jury or		1 ☑ Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Othe	r (Specify)	State E	cemetery, cre Sel Air	Memor	ial (Gdns ?						ryland
Bal	permit. Peges 1 a Department of He Important: if Item any injury or other		21. Signature of Funeral Sen	J. C	200	11	> ²	Tar Abe	ring rdeei	s of Facili -Caro n, Ma	o Fu ryla	neral H nd 210	Iome)01-	3399	Α.	
			23a, Part1. Enter the diseas shock, or heart failure.	e, or comp	lications that one cause on e	caused the d										Approximate Interval Between
ı	Physician		Immediate Cause (Final	List only	5-	DTIA	Sha	-11								Onset and Death
411	/Medical		disease or condition resulting in death)		a. Due to	or as a con	sequence of):	CK							-	5 hRS
	Examiner				R:	ATE		NEU	mo	NIA					4	HIKIDOCE N
		Je.	Sequentially list conditions, if any, leading to immediate		Due to		sequence of):	1000)10/1/00 CC /1
	tate be executed by sicien end the burial-transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1												
Ċ.	exec n end ial-tra	Exa	resulting in death) Last		Due to	(or as a con	sequence of):									
8760,	e be sicie e bur	dicai		ı	d.											
89	ificat g phy as th	edi			-											
Вох	eath certific attending p	2	IF FEMALE: 23b. Was decedent pregnan		23c. If yes, ou									23d. Dat	e of deliv	very
ă	The law requires that the death certificate be executed ste has been signed by the attending physicien end page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No			birth 2 □ F nant at time		⊒Ectopic pr ⊒ Other (sp					- 1	Mo		Day Year
P.0.	by the detached	hys	9 Unknown	2000	9□ Unkn	own										
	thet		Part II. Other significant con	ditions co	entributing to d	leath but not	resulting in the t	inderlying c	ause give	n in Part I		23e. Did t	obacco	use conti	ribute to	the cause of death?
Vital Records,	uires n sign	d by						_				1 🗆	Yes :	2 □ No	3 🗆 Pro	bably 4 🛣 Unknown
00	w requir been si should i	Completed										24a. Was	an	24b. V	Vere aut	opsy findings available
Re	The lav	盲						· · · · · · · · · · · · · · · · · · ·				auto	osy irmed?		death?	ompletion of cause of
a		ပိ	25 Man ages referred to me	digal								1 Yes	2 🔀 N	lo 1	I ∐ Yes	2 🔀 No
₹	Physician: r this certific ral director,	00	25. Was case referred to me examiner? 1™ Yes 2□ No		Hospital:	Inpatient 2	DED/0.45-45-		Othe	· ·		h (Check only o		0 1704		
8	<u>a</u> = <u>e</u>	1	27. Manner of Death				2 ER/Outpatie		/A	4 🗆 🛚 🕦		me 5 Resi 28d. Describe				(Ty)
ion	ittending F death. ctor: After y the funera	ation	1 Matural 5 ☐ Pe 2 ☐ Accident inv	estigation		of Injury oth, Day Year	r) Injury	м	8c. Injury Work	? ∕es 2 □						
Division	of or Attendated death Director:	Certification:	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide de	uld not be termined	280. Place	e of Injury - A ling, etc. (Sp	At home, farm, st ecity)	reet, factory	, office			28f. Location (City or To			er or Rui	ral Route Number,
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical C	29a. Certifier 1 Carl (Check only 2 Mad	ifying Phy ical Exam	inar: On the b	e best of my easis of exan	knowledge, dea nination and/or in	th occurred ivestigation	at the tim	e, date an pinion, dea	id place, ith occuri	and due to the red at the time,	cause(date ar	(s) and ma	nner as a	stated. to the cause(s)
1	o the ithin o the	Me	29b. Signature and title of ce	rtifier	uno man			290	. License	number			29d. D	ate signed	d (Month,	, Day, Year)
1	F 3 F ŏ		170	2	7	7		1	155	27.	7		1			
			1 (My)	19	D L	SO OF 40-41-1	Item 23a\ (T		. 55				U/T	O U Jik	7	1,2000
			30. Name and address of per	son who d	Ompleted cau	se or death (UNIO	- /1	VE	H	ALIC	do (704	400	Mn	1,2006
-	Sta	to	31. Date filed (Month, Day, Y	ear)	32. F	Registrar's Si		,) / (V 1-	1	11016	- ue c	- 1	10e	1410	21018
	Regist		JAN 1 8	2000	A	1	house	20								
DI	MH 17 Rev 1/2		STATE O	ZUUb.	J. Wallet	as Il	A TOPPE									

			For State Registrar	State of		nd / Depa		f Health	and M	lental Hyg		006	01279
	Discrete:		1. Decedent's Name (First, Middle, La							2. Date of Dea Month	ıth	Year	3. Time of Death
	Physici /Medi		KATHRYN LOUISE				4b. City, Tow	n or Legation		January	12 Day	2006 ounty of Deat	11:50 A M
	Examir	er	4a. Facility Name (If not institution, giv Upper Chesapeake			:	Be1		II OI Dealii			Harfor	
	Funeral Director		200 21 2000	ex 7. □ M 21XF	Age (In yrs.	last birthday) Yrs.	If Under 1 Ye Months Da		er 24 Hrs. Min.	8. Date of Birth 3/10/19	year)	9. Birt Co Mar	hplace (State or Foreign unity) yland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	Mary e-f sh	ctor	MD Harfor	ď	74	Whitefo.	rd 						1 ☐ Yes 2 📉 No
ئے	within 72 hours after death with the Maryland within 72 hours after death with the Maryland ane. than "natural", or Itema 23a or 28e-f show he Medical Examinar round by notified at	by Funeral Director	10e. Street and Number 4034 Tabernacle R	oad				1160				on of What Co USA	untry?
am	er dea	uner	11. Marital Status	12. Was Decede	ent Ever in Ues?				Origin? (Sp an, Puerto	ecify Yes or No- Rican, etc.)	14	. Race - Ame Black, White	
500	urs aft	by F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 If Yes, Give Year or Date		1	☐ Yes 2 ☐	No <i>Specit</i>	fy:		S	pecify: Wh	ite
= L	72 ho	Completed	15. Decedent's E	ducation ide completed)		16a. Deced	ent's Usual Oc kind of work do OO NOT use re	cupation ne during m	ost of work	ing	16b. Kind	of Business/	Industry
2121	within ene.	ompi	Efementary/Secondary (0-12)	Coflege (1-4	or 5+)	1	k/Merch				Reta	il Sal	es
		To Be Co	17. Father's Name (First, Middle, Last, James R. Dowlin			<u> </u>				e (First, Middle, certon H			
	Mal ylallud nd 2 should be fit tilth and Mental Hy 27 is marked other traumatic even	-	19a. Informant's Name/Relationship (James Morris/S							Street,	-	70wn, State, 2 21154	[ip Code]
1/12	Pages 1 avment of Heamant: If Item		20a. Method of Disposition 1XD Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		20b. Fak	Place of Dispondence	sition (Name of natory or other e Cemet	place) ery		Date /2006		ition - City or eford,	
) /	permit. F Department Importar any injur		21. Signatur of uneral Service Licer		- On		Name and Adrikins F			e,Inc.,	Delt	a, PA	17314
			23a. Part . Enfor the disease, or com- shock, or heart failure. List only	plications that cau	sed the deal	n. Do not ente	er the mode of	dying, such a	as cardiac	or respiratory ari	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Ca	ste !	Kespi	-	64	Sure				nours
	/Medical Examiner			Due to (or	as a consec	quence (f):	to 1	10005	Poi	Pune			days
	*	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a consec	quence of):	ace 1	200	Pin	A.			- J
. "	be executed sicien and burial-transit	Examiner	Cause (Disease or infury that initiated events resulting in death) Last	c. far	as a Jonsed	mal (atrial	te	brill	aleon		-	days
2	e be ex /sicien a	cal E	(Mes	tasta	tic 1	riman	Lu	ne	Cancer	,		months
0	- w > w			d. //[x/	2007,10	7.C Y	0	<u> </u>	0				
Phill	death death e atte	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outco 1 ☐ Live birtl 4 ☐ Pregnan 9 ☐ Unknow	h 2 ☐ Feta it at time of c	aldeath 3□	Ectopic pregna Other (specify				23	d. Date of del Month	ivery Day Year
2	The law requires that the tee has been signed by the bage 2 should be detached.	by Pi	Part II. Other significant conditions	0	th but not res	sulting in the ur	0 - 0	- 0	_				the cause of death?
thr	v requir been si	eted	massure pr	euras e	Dusi	m le	M SIde	- J. C.	everi 1	24a. Was a	'es 2 🗆		obably 4 Unknown utopsy findings available
Kath	The lav	Completed	a cortic muy	irysin		arge	Ws con	ding 1	nozac	autop:		prior to death?	completion of cause of
Vital	ysicien: The scartificate director, pag	Be	25. Was case referred to medical examiner?	0						h Check only or	ne		
	this all dir	. To	1 Tes 2 No	Hospital: 1 Inc	Injury	ER/Outpatien		njury at		me 5 Resid			cify)
	in the line	ation	1 Natural 5 Pending 2 Accident investigatio	(Month,	Day Year)	fnitury	1	Work? 1 ☐ Yes 2			. ,		
	UNSION Ne Hospital or Attending n 24 hours after death. Ne Funeral Director: After pletely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	208. Flace 0	f fnjury - At h I, etc. <i>(Speci</i>	nome, farm, straify)	eet, factory, off	ice		28f. Location (S City or Tow		Number or Ru	ural Route Number,
4 3	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	Medical (29a. Certifier 1 Certifying Pl (Check only 2 Medical Executions)	nysicien: To the b miner: On the bas and manne	is of examina								
-12	To the within 2 To the complet	Me	29b. Signature and title of certifier	0				ense numbe			1/	signed (Mont	
	٠,		Clhest S.	Jun,	M. W.	m 22a) //	Drint)	- 18	177	7	anua	ry 12,	2006
	13		30. Name and address of person who	N.M.D.	1716	Hartor	1 Road	Sain	te 105	, Falls.	ton,	MD	, 2006 21047
	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 2 0 200		istrar's Sign	ature	w						

			1 - For State Registrar	State of Man		artment of H			ene 005	01280
3	Physici	20	1. Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death
	/Medic		Thaysma Josefir					June	us 6,200	69:50AM
**	Examir	ner	4a. Facility Name (If not institution, give Washington Cour		1	Hage	r Location of Dea erstown		Washingt	on County
Take.	Funeral Director		5. Social Security Number 6. Se 1214–23–5188	x ☐ M 2[X]F 7. Age (/	n yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days	Hours Min	. (Month, Day,	9. Binth Cou 1 1957 Vene	nplace (State or Foreign intry)
	pu »		Usual Residence of Decedent 10a. State 10b. County	11	Oc. City, Town or Lo	nation	· · · · · · · · · · · · · · · · · · ·			
	Maryia -f ehov lied at	tor	Maryland Washing		•	gerstown				10d. Inside City Limits 1 ☐ Yes 2 No
	ith the	Director	10e. Street and Number	_		10f. Zip Code	4740	10	g. Citizen of What Cou	untry?
	ath w	ra	21818 Mt. Aetna				1742		U.S.A.	
336	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygjiene. Item 27 is marked other then "naturel", or items 238 or 28s-f ehow other traumatic event, the Madical Examinational Carlottical at	by Funeral	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub. 1 Y Yes 2 No	dispanic Origin? (San, Mexican, Puel Specify: Venezu	Specify Yes or No- rto Rican, etc.)	14. Race - Amer Black, White Specify: H	ican Indian, , etc. ispanic
21215-0036	in 72 hou	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	ation	1	6b. Kind of Business/li	ndustry
212	d with giene.	omo:	Elementary/Secondary (0-12)	College (1-4or 5+)		memaker	,		Personal	Residence
Maryland	2 should be fited within and Mental Hygiene. Is marked other then eumatic event, the Ma	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, M dis Tovar	faiden Surname)	
2	should nd Men marke	T ₀	Armando Castaneda 19a. Informant's Name/Relationship (T)		19b Mailir	nn Address (Street			City or Town, State, Zi	in Code)
, Ma	and 2 seath and 2 seath and 27 is e		Edson E. Rubert						wn Maryland	
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is eny Injury or other trau		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	•	natory or other pla	1		20c. Location - City or T	
altin	mit. Parantme sortani / Injury		4 □ Donation ² 5 □ Other (Specify) 21. Signature of Funeral Service Licens			ing Crema 2. Name and Addre			mithsburg M Fiery Fune	_
Ä	9 Q E 9		Daniel .	1. Yauley		331 East	ern Blvd	l. N. Hage	rstown Mar	yland 21742
			23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.					st,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a c	onsequence of):	D. Year	t (n	ncer		3 years
	Examiner		Sequentially list conditions,	b						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c	ontaquenta ory:					
,00	cate be executed physicien and the burial-transit	I Exa	resulting in death) Last	Due to (or as a c	onsequence of):					
8760,	physic physic the b	dical		d						
O. Box 6	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of delive Month	very Day Year
s, P.	es that thighed by	by Ph	Part II. Other significant conditions co	ntributing to death but n	ot resulting in the u	nderlying cause giv	en in Part I.		acco use contribute to	
ord	w require been si should t	ted						1 🗆 Ye	s 2⊡No 3□Pro	bably 4 Unknown
		Completed						24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of
/ita	ysician: is certifica director, p	Be	25. Was case referred to medical examiner?	I		l au		ath (Check only one		
of	hys this al dii	2	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatier			Home 5 Resider	nce 6 Other (Speci	nfy)
	Attending r death. ector: After by the funer	atlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y	ear) Injury	Wor	k? Yes 2 □ No	Zad. Describe no	w injury occurred	
Division	ial or Attending F s after death. al Director: After i ad in by the funera	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Rui State)	ral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical (29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of n ner: On the basis of ex and manner stated	amination and/or in	n occurred at the tir vestigation, in my o	me, date and plac pinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier			29c. Licens			d. Date signed (Month,	, Day, Year)
			> muhael of	. Thehew			4166		1.6.0	۲
35F	1-5		30. Name and address of person who come is the company of the comp	Cornect	i//10 Me	Print) Nicol Co	my cr 1	tagenton	n mo	21742
	Sta Registi	-	31. Date filed (Month, Day, Year) JAN 1 0 20	06 Secur	M. Ap	who				

		1	State of Maryla		artment of F			iene 006	01281
	Physicia	ın	1. Decedent's Name (First, Middle, Last) Valerie Prochnik Ragland	1			2. Date of Deat Month 01	Day Yeer 04 2006	3. Time of Death 9:45p M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) William Hill Manor		4b. City, Town, o	r Location of Death ton		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 X F 89	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 8 – 25 – 1	Year) Cou	place (State or Foreign intry) aul, Mn.
	ryland how		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo					10d. Inside City Limits
	r 28a-fs	Director	Md Talbot 10e. Street and Number	East	On 10f. Zip Code		1	0g. Citizen of What Co	1 ☐ Yes 2 X No untry?
	3a or		501 Dutchmans Lane		2160	1		USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "naturel; or tiems 23a or 28a-f show other traumatic event, the Medical Examinating the collidation.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XNo		pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Amer Black, White Specify: Wh	, etc.
Maryland 21215-0036	within 72 hou ene. than "nature he Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired al Esta	during most of wor d)		16b. Kind of Business/I	•
and 21	ould be filed within Mental Hygiene, arked other than '	Be	12 years 17. Father's Name (First, Middle, Last) Edgar L. Prochnik	1.0.		18. Mother's Nan		Maiden Sumame) James	
Maryl	nd 2 should that and Meniting and Meniting 27 is marked traumatic	<u>م</u>	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Number	r, City or Town, State, 2 Washingt	ip Code) 20007
Baltimore, I	ages 1 and 2 ant of Health it: If itam 27 i y or other tre		20a. Method of Disposition 20th	o. Place of Dispo		ce)	Date	20c. Location - City or Dover, De	Town, State
Baltir	permit. Pages Department of t Importent: If its any injury or of once.		21. Signature of Funeral Service Licensee	R	2. Name and Addre	ll Hurl	ey Fune	ral Home,	PC
	Pnysician	Ų.	23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	eath. De not en	ter the mode of dyn	518, S	Mich or respiratory arr	aels, Md.	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consulting sequentially list conditions,	on he	led D.	wheter r	Pollitas		Zotyes
1,092	ate be executed sysician and he burial-transit	Icai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a constitution of the cause) Due to (or as a constitution of the cause) Due to (or as a constitution of the cause)						
P.O. Box 68	death certifica e attending ph ed for use as t	by Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 ryonths? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of del Month	ivery Day Year
	Se US	d by Ph	Part II. Other significant conditions contributing to death but not	resulting in the u	underlying cause gi	ven in Part I.	23e. Did to 1 🗆 Y	bacco use contribute to es 2 ∰No 3 ⊟ Pr	the cause of death?
Records,	The ate h	Completed	Macular decement	x Do	lslore		24a. Was a autop perfor	sy prior to death?	stopsy findings available completion of cause of
Vital	ilcian: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				ath (Check only or		
ō	Phys this ral di	ပု	27. Manner of Death 1 Matural 5 Pending 28a. Date of Injury (Month, Day Yea.	28b. Time of Injury	of 28c. Inju			lence 6 Other (Spe low injury occurred	zify)
Division	or Attending after death. Director: After in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - 4 building, etc. (Sp.	At home, farm, st ecify)			28f. Location (S City or Tow	Street and Number or Run, State)	ıral Route Number,
_	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	edical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of examinand manner stated.	knowledge, dea nination and/or i	ath occurred at the t nvestigation, in my	ime, date and place opinion, death occ	e, and due to the durred at the time, d	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier // Lllam Hyos	zl) M	29c. Licen	se number 08719		29d. Date signed (Mont	h, Day, Year)
	R-		30. Name and address of person who completed cause of death William H. Wood, Jr. MD			s Lane	Easton	, Md. 216	01
	St Regist	ate rar	31. Date filed (Month, Day, Year) 11. Date filed (Month, Day, Year) 12. Registrar's S		L			,	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year MARJORIE LOUISE RAYE JANUARY 12,2006 10:15A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHARLES 11519 REST PLATA DRIVE T. A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) FEB. 14, 1928 9. Birthplace (State or Foreign **Funeral** Days 1 □ M XIXF Hours Yrs. **Director** MINNESOTA 300-20-6926 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28e-f show traumetic event. The Medical Examiner must be notified at 1 ☐ Yes XXNo Director MARYLAND CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 items 23a 20646 U.S.A. 11519 REST DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yes 2 X Xo If Yes, Give Year or Dates: 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) LICENSED OPTICIAN OPTOMETRY OFFICE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EMMETT J. MC CARTY BEATRICE P. POTTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 11519 REST DRIVE, LA PLATA, MD 20646 D.LEONARD RAYE-HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) METROPOLITIAN CREMATORY 01-14-06 ALEXANDRIA, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility и00479 RAYMOND FUNERAL SERVICE, P.A. T.A. PLATA, MARYLAND
Do not enter the mode of dying, such as cardiac or respirator 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician he disease or condition resulting in death) /Medical Due to (or a a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. the þ signed t d be deti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 SKYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 29 Was case referred to medical Be 26. Place of Death (Check only one) Cther: 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3∏ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attending Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I To the 29b. Signature and title of certified 0008 address of person who completed cause of death (Item 23a) (Type, Print) agrange 32. Registrar's Signature State Registrar

Harry P. Robertson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#2 a,27,penf ,652,2/1/06 State of Maryland / Department of Health and Mental Hygiene 06 - 326AKG Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Harry P.T. Robertson January 13, 2006 9:24 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 715 Brandon Circle Charles Waldorf If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1**™**M 2□F Yrs. Maryland 50 8-28-1955 Director 217-68-7098 Usual Residence of Decedent 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits Hygiene. other than "natural", or itema 23a or 28e-f ehow ent, the Musical Examinar must be notified at 1 Yes 2 No Completed by Funeral Director Maryland Charles Waldorf the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20602 715 Brandon Circle USA filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled 4 years None other permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyginportant: if liem 27 le marked eny injury or other 12. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robertson Virginia McCann Elliot ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 528 Coxswain Way, Annapolis, MD 21401 Virginia Robertson/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☆ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-15-06 Kalas Crematory Edgewater, MD 21. Signal of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home Ulla www 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atherosclerotic Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed anding physicien and use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. F 9 Unknown ρ sete has been signed | page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes certificete 2 □ No Hospitel or Attending Physician: After this certification 25. Was case referred to medical 26. Place of Death Check only one examiner' Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 XYes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 24 hours efter on Funeral Direct 4 Homicide 29a. Certifier 🗆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29b. Signalure and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

Mune

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OREU

32 Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

January 14, 2006

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANUARY 14 2006 **Physician** DONALD 9:38 a^M ROBERT REED /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Chester River Hospital Center Chestertown Kent If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept 8 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F Yrs. 221-28-5535 64 1941 Delaware **Director** Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits ir than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director MD Kent **Galena** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14065 Augustine Herman Hwy. 21635 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Aero Space Engineer Rocket Engineering 5 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or othar traumatic evant Millard Filmore Reed Florence Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan M. Reed 21635 (wife) P.O.Box 63 Galena, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Kent Cremation 1/17/06 Smyrna, DE. ⁴ □ Donation 5 □ Other (Specify) 21. Signal of Funeral Service Licen 22. Name and Address of Facility Galena Funeral Home of Stephen L. M00510118 West Cross St. Galena, MD. 216 Schaech 21635 Approximate Interval Between Onset and Death Forth Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Infarction Immediate Cause (Final Myourdia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner thlerosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner certificate be axecuted burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physicien Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2 1 No 1 Yes director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 \(\text{\text{Nursing Home}} \) 5 \(\text{\text{Residence}} \) 6 \(\text{\text{Other}} \(\text{\text{(Specify)}} \) 1 🗌 Yes 2 🗆 No 2 ER/Outpatient 3 DOA Certification: To this funeral 28c. Injury at Work? 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Hospital or Attanding 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after death uneral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifie 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/14/06 758824 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 M.D. 119 C. North Main St. Galena, MD. 21635 Paul Donaher, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Jeanette Reinhardt Kathryn January 2006 12:43 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Reeders Memorial Home Boonsboro If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb • 13 1913 7 Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 X F Penna. 197-12-8378 92 Feb. Yrs. Director Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show theumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director MD. Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with U.S.A. 141 S. Main St. 21713 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Payroll Clerk Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Arthur H. Snoddy Frances E. Sullenberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: if item 27 is m any injury or other traum once. 13806 Weber Way Hagerstown, Md. 21742 Joan Ross/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Smithsburg Crematory 1/12/06 Smithsburg, MD. 21. Signature of Funeral Service Licensee Zimmerman And Son Funeral Home Inc. 1 Jack 45 S. Carlisle St. Greencastle, Pa. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final corchrovancular accident **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner cancer Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Examine be executed use as the burial-transit signed by the attending physician and d be detached for use as the burial and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☑ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 🗌 No 1 ☐ Yes 2 Division of Vital Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 100 itel or Au.
cours after death.
**al Director: After to.
by the funeral dir 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 00062223 7/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 340 Mills Street, Hagerstown, MD Praveen Bolarum 21740/ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 2 2006

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			For State Registrar	State of Mar	-	artment of Heartificate of De			ene 0 (16	01286
			Decedent's Name (First, Middle, Last)					2. Date of Death			3. Time of Death
п	Physici		Georgia	Myrtle	Car			Month	Day 200	Year	11.16 m M
1	/Medio Examin		4a. Facility Name (If not institution, give st		Sac	4b. City, Town, or Loc	cation of Death	January	4c. County		11:16 p M
1	LXaiiii	CI	Futurecare Chesap			Arnold			Anne		odol
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthday)	If Under 1 Year If	Under 24 Hrs.	8. Date of Birth		9. Birtho	lace (State or Foreign
	Director		577-07-3179 ¹	^{M 2} ∑ F 8	8 Yrs.	Months Days F	Hours Min.	Oct 16.	1917	Mary	try)
	D.		Usual Residence of Decedent								
	show	_	10a. State 10b. County		10c. City, Town or Lo					1	0d. Inside City Limits
	Ma-f-	cto	MD Calvert			Sunderl	and				1 □ Yes 2 X No
	ih th or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	/hat Cour	ntry?
	23e	ia i	920 Dalrymple Road			20689			USA		
	eme	Funeral	11. Marital Status	Was Decedent Ev Armed Forces?		Was Decedent of Hispa if Yes, specify Cuban, N	anic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americ k, White,	an Indian,
36	or It	Y.F.	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give			Specify:		Specify		010.
21215-0036	72 hours after death with the Maryland natural, or Items 23s or 28s-f show dical Examinar must be notified at	d by	3 X Widowed 4 □ Divorced	Year or Dates:						whi	
5		Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occupation kind of work done dunit		ing 10	6b. Kind of Bu	siness/Inc	dustry
12	within ene. then "	E	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired)			1		
	be filed within 72 hours after death with the Maryla nat Hygiene. od other than "naturat", or Items 23s or 28s-f shov event, the Madical Examinar must be notilised as		12 17. Father's Name (First, Middle, Last)		ПС	memaker	Mothode Name	e (First, Middle, M	own l		
ano	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ms	Be		- 1		10.					
Ž	should ind Men in marke	P	Edward Henry 19a. Informant's Name/Relationship (Typ	Lusby	10b Mailie	ng Address (Street and	Maude	Myrt		Dent	
Maryland	ges 1 and 2 should t of Health and Mer if Item 27 is marke or other traumatic		Helen Lusby, sister			Dalrymple				31216, <i>21</i> 0 2068	•
	1 an Heal Hem 2		20a. Method of Disposition	L-III-Iaw	20b. Place of Dispo	sition (Name of	 :		Oc. Location -		
ō	Pages nent of int: If It		1 ☐ Burial 2 X Cremation 3 ☐ Re	moval from State		natory or other place)	-01				
Baltimore,	if. P. rrtme ortani		4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			tan Cremat		03-00	Alexano	шта	, VA
Ba	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any Injury or other tra 2002.		Id Ill on ?	600				. D.3	0-4	. 15	20726
	-		23a. Part1. Enter the disease, or complic	ations that caused the		Rausch Fune				s, ML	Approximate
			shock, or heart failure. List only one Immediate Cause (Final	cause on each line		or the mode of dying, s	don do carciao (or respiratory arres	,		Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	Prell	monic	4					3 days
	Examiner			Due to (or as a	consequence of):						
		P.	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):					-	
	nsit	듣	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
,	exect n and al-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):						
8760,	The law requires that the death certificate be executed sie has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	dicail									
9	ificati g phy as the	ed	<u> </u>								
Вох	leath certific ettending p	Z	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of					23d. Date	e of delive	erv
-	death	Cia	in the past 12 mooths? 1 □ Yes 2 ☑ No	1 Live birth 2 4 Pregnant at ti		Ectopic pregnancy Other (specify)			Mor		Day Year
P.0	that the de led by the detached	Physician/Me	9 Unknown	9□ Unknown							
	signed t	by P	Part II. Other significant conditions cont	ributing to death but	not resulting in the u	nderlying cause given in	n Part I.	23e. Did toba	acco use contr	ibute to th	ne cause of death?
Records,	w require been sig should b	Pg F	Advanced.	#12hes	(mer)	- dame	entra	1 ☐ Yes	2 □ No	3 🗌 Prob	ably 4 Dunknown
ပ္ပ	s been s shoul	olet					. ,	24a. Was an	24b. V	Vere auto	psy findings available
R	sician: The law certificete has t irector, page 2 s	Completed						autopsy	ed?	eath?	impletion of cause of
Vital	an: tifice tor, p	BeC	25. Was case referred to medical			26	3 Place of Death	1 ☐ Yes 2 l		□Yes	2 □ No
>	Physician: this certifical ral director,	다 B	examiner? 1 Yes 2 No	spital:	2 ER/Outpatier	Other		me 5□Residen		ar (Specifi	v)
0	g Ph terth neral		27. Manner of Death	28a. Date of Injury (Month, Day	Year) 28b. Time o	28c. Injury at Work?		28d. Describe how			,
Ö	Attending r death. ector: After by the fune	atio	1 □ Matural 5 □ Pending 2 □ Accident investigation	(Worst, Day	, sur,		2 □ No				
Division of	r Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury	y · At home, farm, str (Specify)	eet, factory, office		28t. Location (Stre	et and Numbe	er or Rura	I Route Number,
ቯ	rs eft al Di	Cer		,	(ony or 1 own,	0.0.0)		
	Hospital or 24 hours efte Funeral Dire tely filled in b	ca	29a. Certifier 1 Certifying Physical Examin	cian: To the best of	my knowledge, deat	h occurred at the time, overtigation, in my opinion	date and place,	and due to the cau	use(s) and mai	nner as st	tated.
	To the Hospital or Attending Physician: The within 24 hours effect death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	Medical	one)	and manner state	ed.						
	or to co	-	29b. Signature and title of certifier	1	_ w	29c. License nu	5A7	フ ズ 290	d. Date signed	(Month,	Day, Year)
	_						00/0		1-3	- 0	XUO
	3		30 Name and address of person who cor	npleted cause of dea	ath (Item 23a) (Type,	Print)	MIL	sville	,	17	21100
	Sta	ate.	31. Date filed (Month, Day, Year)	32. Registra	S Signature	ansi uyi	VIICEST	sville	- jN	11	21108
	Regist		JAN - 3		plus S.	Goodes					

			1 - For State Registrar	State of Marylan	d / Depa		t of H	ealth ar	nd Mental I		2000	5 01287
	Physici /Medic Examin	af	1. Decedent's Name (First, Middle, Last) Charles Howard SMI 4a. Facility Name (If not institution, give st Saint Joseph Ma	treet and number)		4b. City,	Town, or	Location of	Death	JARY	5, 20 c. County of	Death
	Funeral Director	, e	Social Security Number	7. Age (In yrs. 86		If Under Months	1 Year Days	If Under 24 Hours	Hrs. 8. Date of (Month) Dec.	Birth Day, Year 2, 19		9. Birthplace (State or Foreign Country) Maryland
	illed within 72 hours after death with the Maryland Hygiene. Hydiene "natural", or Itama 23a or 28a-f ehow ent, tre Medical Exammer must be inclined at	Director	10a. State 10b. County Maryland Washing 10e. Street and Number		y, Town or Lo		Code			10g. C	itizen of Wh	10d. Inside City Limits 1 ⊠ Yes 2 □ No nal Country?
36	be tiled within 72 hours atter death with the Marylan Hygiene. I Hygiene. I dother than "natural", or Itama 23a or 28a-f ehow event, it e hadical Exam es must be inclined at	by Funeral Director	801 View Street 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U. Armed Forces? 1. ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW I		Was Decedif Yes, spec			n? (Specify Yes or Puerto Rican, etc.			American Indian, White, etc. White
9500-61212	id within 72 hou giene. er then "neture , tre Medicel E	Completed I	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	ation	16a. Deced (Give life. L	kind of woi DO NOT us	al Occupa rk done d se retired	ation luring most o)	of working			ness/Industry
	4 d a a	To Be (17. Father's Name (First, Middle, Last) Lewis T. Smith 19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	ng Address	(Street a	Ethe	s Name (First, Mic 1 Mae Sh or Rural Route Nu	rader	Í	
ຍົ .	t. Pages 1 and then of Health rtant: if item 27 ijury or other to		Helen Smith - wife 20a. Method of Disposition 1	Hag	lace of Dispo emetery, cren erstow	sition (Nam natory or o n Cre	ne of ther place emato	e)		20c. l Ha	ocation - Ci	own, Maryland
	eded in the same of the same o		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	Musuuse that caused the death e cause on each line.	a. Do not ente	15 E. er the mode	. Will e of dying	Lson B	rdiac or respirator	gerst		Md. 21740 Approximate Interval Between Onset and Death
90,	Medical Examiner	Ical Examiner	resulting in death) Sequentially list nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a))).	uence of):	S UK	NHE	F* }={ .1. [UKE.			
POX P	attending p	Physician/Media	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	lc. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	Ectopic pro					23d. Date of Month	
cords, P	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions cont	tributing to death but not resu	ulting in the ur	nderlying ca	ause give	n in Part I.			V	ute to the cause of death?
I Kec	ate has	Be Completed	25. Was case referred to medical					26. Place o	24a. V a p 1 Ye	utopsy erformed? is 2 X No	prio	ore autopsy findings available or to completion of cause of ath? Yes 2 X No
ב ו	After this funeral d	Certification: To E	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At hobuilding, etc. (Specify	ER/Outpatien 28b. Time of Injury	M 2	8c. Injury Work 1 🔲 Y	4 🗀 Nursi	28f. Locatio	be how inju	nd Number	
ַ	To the hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical Ceri	29a. Certifier 1X Certifying Physi	ician: To the best of my knower: On the basis of examinat and manner stated.	wledge death	occurred a	at the tim in my op	e, date and pinion, death	place and due to	the cause/s) and mann	er as stated. d due to the cause(s)
5		Me	29b. Signature and vittle of certifier 30. Name and address of person who com	Fau M.D.	(23a) (Type	D	. License	number 2134		29d. Da	signed (A	Month, Day, Year)
C	Z Sta Registr		TIMOTHY LOW M. D. 31. Date filed (Month) Gay, Year)	76/21 05 E 32. Registrar's Signal	R DRI		ows(AM AC	RYLAND-	2120	4	

	,		State of Maryland / D	Department of Health and None of Certificate of Death	lental Hygi	•	01288
Physici /Medi Examir	cal	Decedent's Name (First, Middle, Last) Ernest Stephen Aa. Facility Name (If not institution, give street)		4b. City, Town, or Location of Death	2. Date of Death Month Jan		3. Time of Death # 2 ! 4/ M
Funeral Director		Washington County 5. Social Security Number 292–34–0791 6. Sex	7. Age (In yrs. last bin	Hagerstown Hagerstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Feb. 13, 1	O Diet	nington nplace (State or Foreign untry) Ohio
TO TO	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Washin 10e. Street and Number	10c. City, Town	n or Location Hagerstown 10f. Zip Code		g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2√ No
L 13-0030 hin 72 hours after death with the Maryland e an "natural", or Items 23a or 28a-f ahow Medical Examiner must be notified at	by Funeral Di	17329 Claymont Dr	2. Was Decedent Ever in U.S. Armed Forces? 1VVYes 2 No 1959- IVes, Give	21740 13. Was Decedent of Hispanic Origin? (Sp ff Yes, specify Cuban, Mexican, Puerto		USA 14. Race - Ame Black, White	rican Indian,
within 72 hoursiene.	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation 16a.	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Technician	ung 1	6b. Kind of Business/	ndustry
Id be filed ental Hygi ked other	To Be Co	17. Father's Name (First, Middle, Last) George John Stet 19a. Informant's Name/Relationship (Typ.				aiden Sumame) Gurtsak	
or other		Carolyn Stetak - W 20a. Method of Disposition 1 X Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	7329 Claymont Drive	Hagersto Date 2	1072 53	own, State
permit. Pag Department Important: any injury o		21. Signifure of Juneral Service License	QL	GSBOTHE AT THE FAILY HOR 425 S. Conococheagunot enter the mode of dying, such as cardiac	ne,P.A. ue St.Wil	liamsport,	
be to be executed by the principle of th	dical Examiner	shock, or heart fail@re. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in	Due to (or as a consequence Proportion of the consequence Proportion of the consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Chroma Obst	preumonia or): Cell lung Cans	na ma	lase	Interval Between Onset and Death
the death certify the attending with attending ached for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of deli Month	very Day Year
equires that een signed b		Part II. Other significent conditions cont	ributing to death but not resulting in	n the underlying cause given in Part I.		acco use contribute to	the cause of death?
vical necolus, aician: The law requires t certificate has been signe rector, page 2 should be	e Completed by	25. Was case referred to medical	ionizopaly	26 Place of Dead	24a. Was an autopsy perform 1 Yes 2	ed? death?	topsy findings available completion of cause of 2 No
Phy C	ation: To B	eyaminer?		Other		nce 6 Other (Spec	cify)
DIVISION spital or Attending tours after death. neral Director: After	ai Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	City or Town,		
To the Ho within 24 h	Medical	(Check only one) 2 Medical Examin 29b. Signature and title of certifier	er: On the basis of examination an and manner stated.	29c. License number D 6 2 5 6 2 (Type, Print) MAPH AM FLO	red at the time, da	te and place, and due d. Date signed (Monti	to the cause(s)
St Regist	ate trar	31. Date filed (Month, Pay, Year) JAN 0 6 200	MITTER PROSPETA	L MAGGER / Thinks	MARYLA	mo 2174	O

06-	k John -00175	Su	llivan P leas Unpend: item# 23	e Type or Pri	nt in Black I	ndel ibl e Ink	. Ensure All	Copies	Are Leg	ible.	
C	11		Unpend: item# 238 1 - State Ragistrar	State of M	iaryiand / Dep	partment of leartificate of	Health and M	entai Hyg	jiene	16	01289
	Physici /Medio	cal	1. Decedent's Name (First, Middle, Patrick Joh	n Sull:		dh Chu Taun	and ageting of Death	2. Date of Dea Month Januar	Day y 7, 20	Year 006 ov of Death	3. Time of Death $10:04 \text{ A}^{\text{M}}$
6969	Examir Funeral	ier		al Hospital	ge (In yrs. last birthda	Fredric	If Under 24 Hrs.	8. Date of Birth (Month, Day	Fredr	cick 9. Birth	place (State or Foreign
9	death with the Maryland oms 23a or 28a-f ehow or frives be notified at	Director	217-08-3397 Usual Residence of Decedent 10a. State 10b. County Maryland Freder 10e. Street and Number		21 Yrs. 10c. City, Town or Mony	Location OV1a 10f. Zip Code		July 4,	1984		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
1215-0036	2 hours after aturel; or ite	Completed by Funeral Dir	3618 Melinda Co 11. Marital Status 1⊠ Never Married 2□ Married 3□ Widowed 4□ Divorced 15. Decedent's (Specify only highest Elementary/Secondary (0-12)	12. Was Deceden Armed Forces 1 KYes, Give Year or Dates Education grade completed) College (1-4or	770 Hispanic Origin? (Specian, Mexican, Puerto For Specify: pation during most of workingd)	? (Specify Yes or No- uerto Rican, etc.) 14. Race - A Black, V Specify: working 16b. Kind of Busine			·		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 7 Deperment of Heelih and Mental Hygiene. Important: If Item 27 ie marked other than "neny injury or other traumatic event, the Med <u>once</u> .	To Be Cor	17. Father's Name (First, Middle, La Dean Patrick 19a. Informant's Name/Relationship Linda M. Sulliv 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Control of Contro	Sullivan o (Type, Print) an / Mother o (Bemoval from State	19b. Ma 3618 20b. Place of Discemetery, co	Melinda position (Name of rematory or other pla Heaven Ce 22. Name and Addr	Court Mon ace) Janua	Marie Marie Marie Marie Marie Marie Number rovia, ate ry 14, 2006	Maiden Surna aurer r, City or Towr Maryla: 20c. Location Silver Funeral	n, State, Zip nd 21 - City or To Sprin Home	o Code) 770 own, State ng, Marylanes, P.A.
8760,	Physician /Medical Examiner but and but and but and transit sthe purial-transit	dicai Examiner	23a. Part1. Enter the dise se of conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Combine Due to (or a		enter the mode of dy	ing, such as cardiac or	r respiratory arr			Approximate Interval Between Onset and Death
P.O. Box 68760,	of the death certific by the ettending parached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		2 Fetal death 3	B Ectopic pregnand	су			ate of deliver	ery Day Year
Records, P.	aw requires the s been signed 2 should be de	Completed by Ph	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cause g	ven in Part I.	11	es 2 No	3 Prot	he cause of death? pably 4 Unknown posy findings available ampletion of cause of
Division of Vital Records,	anding Physicien: sath. or: After this certific he funeral director.	Certification: To Be Co.	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga 2 Accident 3 Suicide 6 Could no determin	28a. Date of Ing. (Month, Date of Ing.) 1/7/2006 28e. Place of Ing. (Month, Date of Ing.) 28d. Date of Ing. (Month, Date of Ing.)	9:19 njury - At home, farm, etc. (Specify)	of PDC 28c. Inju	ork? Yes XXNo	1 d Yes Check only on ne 5 d Reside 8d. Describe ho	2 No pe) ence 6 Ot ow injury occu	rred Unix	(y)
ر مرا	To the Hospitel or Atti within 24 hours after de To the Funeral Directo completely filled in by the	Medical Co	(Check only 2 Medical E	Physician: To the best caminer: On the basis and manner s	of examination and/or	ath occurred at the t investigation, in my	ime, date and place, a opinion, death occurre	and due to the co	ause(s) and m late and place	anner as s , and due to	stated. o the cause(s)
	To with Com	2	29b. Signature and title of certifier 30. Name and address of person w	ne Usul	LMA	OCM	se number		9d. Date signi January		
	Sta	ate	MANYANTO D 31. Date filed (Month, Day, Year)	-KURELL 32. Regis	■ r's Signature	111 Penr	n Street, I	Baltimon	re, Mar	yland	1 21201
	Regist	rar	JAN]	2 2006	ten b	Amei					

DHMH 17 Rev 1/2001

		1	For State Registrar		State of	Marylan		artment of H		nd Mer		giene	006	01290
	Physicia		1. Decedent's Name (First, N	iddle, Last)							Date of Dea	ath Day	Year	3. Time of Death
	/Medic Examin	al -	AMELIA LOU 4a. Facility Name (If not instite	SMI' ution, give si		ber)		4b. City, Town, or	Location of		anuo		County of Deal	3;50AM
	LXAIIIII	C.	Manokin	Mar	YOU			Prin	cess	Ann	e	C	ome	rset
П	Funeral Director		5. Social Security Number 213–14–7382	6. Sex 1 ☐	M 210 F	7. Age (In yrs.	last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birt (Month, Da 0/08/1	h y, Year) 914	Co	thplace (State or Foreign ountry) t Virginia
	ס		Usual Residence of Deceder 10a. State 10b. Co				y, Town or Lo	enting			7,007	711	, wes	10d. Inside City Limits
	Maryla -f shov ied at	tor		ester			comoke							1 X Yes 2 ☐ No
	th the or 28e e notifi	Director	MD Word	ester		FOC	JOHONE	10f. Zip Code				10g. Citiz	zen of What Co	ountry?
	ath wi	ral	205 Cedar St				- 1:-:	21851					USA	edica tadea
36	irs after de il', or Items	by Funeral	11. Marital Status 1 □ Never Married 2 □ 3 ※ Widowed 4 □ Divo	Married	Armed For 1 ☐ Yes If Yes, Give Year or Da	2 ⊠ No ∍		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🏿 No	Specify:	in? (Specify , Puerto Ric	y Yes or No an, etc.)		14. Race - Ame Black, Whit Specify: W	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other treumatic event, I'm Medical Eraci ir er must be notified at once.	Completed	15. Dec (Specify only h Elementary/Secondary (0-	-		4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most	of working		16b. Kir	nd of Business	/Industry
121	iled wi Hygien ther th		7 17. Father's Name (First, Mic	Irlia I ast)			Labor	<u>- </u>	18 Mothe	r's Name (F	iret Middle		duction	n
Maryland	utd be f Aental H rked of tic ever	To Be	Thomas Joseph							a Hufi		margarr	oumame)	
lary	2 short and N ls ma		19a. Informant's Name/Rela					ng Address (Street						
e, P	1 and Health tem 27	1.8	Frances Hurle 20a. Method of Disposition	₃y (da	ughter	20b. F	Place of Dispo	Center St	Ţ	Pocon			MD 218 cation - City or	
E OE	Pages ient of nt: If if		tX Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth		emoval from S	state _	cemetery, crei Lem Cer	natory`or other plac netery		1/07/2	2006	Pocc	moke C	ity, MD
Baltimore,	permit. Departrimporte any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Melson Funer 103 Linden Ave., Pocc										P.A.	1851
			23a. Part1. Enter the disease shock, or heart failure.	e, or compline List only on	cations that ca	used the deat ach line.				T			d. 500 - 500	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	ı			roid Com	ur				- 4	Oliser and Death
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	execut n and ial-tran	Examine	that initiated events resulting in death) Last	c	Due to (or as a consec	quence of):							
8760,	icate be executed physician and s the burial-transit	dlcall			l									
.O. Box 6	The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Mec	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1(1☐Live bi	come of pregninth 2 Feta ant at time of cown	al death 3[□Ectopic pregnancy □ Other (specify) _	/			2	3d. Date of de Month	livery Day Year
<u>α</u>	s that the ned by a detact	by Ph	Part II. Other significant co	nditions cor	ntributing to de	ath but not res	sulting in the u	inderlying cause giv	en in Part I.		23e. Did t	obacco u	se contribute to	o the cause of death?
ords	w requires been sign should be										1 🗆 '	Yes 2	2/No 3 □ P	robably 4 Unknown
Il Records,		Completed									24a. Was autor perfo 1 Yes		24b. Were as prior to death?	utopsy findings available completion of cause of
Vital	Physicien: T this certificat ral director, pa	Be	25. Was case referred to me examiner?	-	lospital:		150/2	Ott		of Death (C				
of	ig Physter this	n: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 P	-	28a. Date 0		ER/Outpatie 28b. Time o Injury				5 🔲 Resi		S □Other (Spe y occurred	ecity)
Division	tendir death. tor: Af the fur	catlo	2 Accident in	ending vestigation ould not be				M 1 🗆	Yes 2 1		Location /	Ctrant and	d Museum or O	ham I Coasta Alamba
DİVİ	el or Al	Certification:	4 ☐ Homicide	etermined	286. Place buildir	ng, etc. (Speci	ily)	reet, factory, office		201	City or To			ural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (29a. Certifier 1 Ce (Check only one) 2 Me	tifying Phys dical Exami	ner: On the ba	best of my kn asis of examinater stated.	owledge, dea ation and/or in	th occurred at the timestigation, in my control	me, date an opinion, deal	d place, and th occurred	due to the at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
	To the To the Comp	Ň	29b. Signature and title of c	- 1				29c. Licens					e signed (Moni	
,			> zuli			SHA NA			57359)		Dar	5/5 >	006
0	H. 3		30. Name and address of polymers (1415 - \$ - 1)						1804					
	St Regist	ate rar	31. Date filed (Month, Day,	0 6 2	006 32. 1	gistrar's Sign	ature	mo?						

(TB 3:50Am

Amelia Smith

			. For					Health and N	•	ene		
			1 - State Registrar			Cei	tificate of	Death	Re	g. Nd. 006	01291	
	Physici	an	1. Decedent's Name (First, Middle, Last,)					2. Date of Death Month		3. Time of Death	
	/Media	al	Mary B. Spear				45 O'A T		January		8:57 p м	
	Examin	er	4a. Facility Name (If not institution, give 331 Dorchester Av					or Location of Death Imbridge		4c. County of Dea		
Ŧ	Funeral		5. Social Security Number 6. Sec		e (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		thplace (State or Foreign	
	Director		213-14-7342	M 2 4 8	85	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, June 13,	1920 Mai	ryland	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c, Cit	y, Town or Lo	cation				10d, Inside City Limits	
)	Maryli f eho	ō	Maryland Dorchest	tor		, .	Cambridge				1 ☐Yes 2 ☐ No	
	r 28a	irec	10e. Street and Number	LCI	1		10f. Zip Code	=	10	g. Citizen of What Co	ountry?	
	should be filed within 72 hours after deeth with the Maryland of Mental Hygiene. marked other then "naturet", or items 23a or 28a-f ehow imatic event, the Modical Exhanites mail be notified at	Funeral Director	331 Dorchester Av	zenue				21613		Ţ	JSA	
	tems	uner		12. Was Decedent Armed Forces?		S. 13. \	Was Decedent of h	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit		
9	rs afte	by F	1 Never Married 2 Married 3 ₩idowed 4 Divorced	1 ☐ Yes 2 ☑1 If Yes, Give Year or Dates:	No		1 □ Yes 2 □ NO	Specify:		Specify:	√hite	
51215-0036	2 hou	ted t	15. Decedent's Edu	cation		16a, Deced	dent's Usual Occup	pation	11	16b. Kind of Business/Industry		
2 2	thin 7;	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5	5+)			pation during most of work d)	ing	Electroni	ic	
7	filed wil Hygien other th	Con	11			Shippi	ng Clerk			Manufactu	ring	
פעב	be data	Be	17. Father's Name (First, Middle, Last)	Downer	Can				e (First, Middle, M.			
Maryland	should ind Men marke umatic	2	Charles Lawson 19a. Informant's Name/Relationship (Ty	,	Sr.	19b Mailin	ng Address (Street			te Barnes City or Town, State, 2	Zin Code)	
	2 4 8 9		Wilhelmina Spear (aught	1				bridge M		
Baltimore,	m O		20a. Method of Disposition 1 Burial 2 Cremation 3 DF				sition (Name of natory or other pla	ce)		0c. Location - City or		
Ē	Pages ment of ent: If it ury or o		1 □ Burial 2 □ Cremation 3 □ F 1 □ Donation 5 □ Other (Specify)		- 1			1	/2006 C	ambride.	MD	
ă	permit. Pages Department of importent: If ii any injury or once.	1	Signature of Funeral Service Licens	ee L				ess of Facility Comwell Fu St., Camb				
_	00.5 8 0	(23a, Part 1, Enter the disease, or compi	13/12	UCC	Do not ont	808 High	St., Camb	ridge, M	D'21613	Approximate	
			shock, or heart failure. List only of	ne cause on each lii	ne.			ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)	aDue to (or as			nfarct				24 hours	
	Examiner		Conventially list sanditions	b								
	p #	iner	Sequentially list conditions, france, learning to announate cause. Enter Underlying Cause (Disease or injury that initiated events	Dies to (or se	a consequ	uarios ory:						
	be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consecu	uence of):						
/60,	ate be executed hysicien and he burial-transit	calE		200 10 (0) 20	u 00113041	uonou on).						
28	ificate g phys as the			0.								
ŏ	leath certifica attending pl	M/W	23b. was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			lEctopic pregnanc	,		23d. Date of del	ivery	
ה מ	b death	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at			Other (specify)	y 		Month	Day Year	
J.	res that the de signed by the a be detached f	Phy	9 ☐ Unknown Part II. Other significant conditions con		ut not reci	ulting in the ur	adorhina cauco an	ron in Part I	23e Did toba	acco use contribute to	the cauco of doath?	
Records,	The law requires that the death certifica tie has been signed by the attending ph cage 2 should be detached for use as th	d by	chronic obstra	1 5	n mo		Disease	on mranti.			obably 4 Unknown	
Š	w require been si should b	iete		· ·		1			24a. Was an	24h Were au	itopsy findings available	
	The la le has age 2	Completed							autopsy	ed? prior to death?	completion of cause of	
Vita		BeC	25. Was case referred to medical examiner?					26. Place of Deat	1 ☐ Yes 2 n (Check only one,		2 NO	
	hysic this ce	မ	1 ☐ Yes 2 🗹 No	Hospital: 1 ☐ Inpatie		ER/Outpatien	1 3LI DOA			ce 6 Other (Spec	cify)	
UC C	ding Physicien: The Ih. After this certificate hatfuneral director, page	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		28b. Time of Injury	Wo	ry at rk? Yes 2 □ No	28d. Describe how	vinjury occurred		
Division of	ten leat lor: the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inj	ury - At ho	ome, farm, str	eet, factory, office		28f. Location (Stre	et and Number or Ru	ıral Route Number,	
É	ai or A s after of Direct	Certification:	4 Homicide	building, et	c. (Specif)	r)			City or Town,	State)		
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely illied in by the funeral director.		29a. Certifier (Check only 2 Medical Exami	sician: To the best	of my kno	wledge, death	occurred at the til	me, date and place,	and due to the cau	use(s) and manner as e and place, and due	stated.	
	To the P within 24 To the F complete	Medicai	29b. Signature and title of certifier	and manner sta	ated:		29c. Licens				**	
	T W I		250. Signature and title of Certifier	16	1		250. Liberts	Enoni		d. Date signed (Mont)		
			30. Name and address of person who co	ompleted cause of d	leath (Item	1 23a) (Type	Print)	70004		January 7	, 2006	
			Mark Malkus	M.D.	408	Byr	~ Stree	t Cam	bridge.	MD 311	613	
	Sta		31. Date filed (Month, Day, Year) JAN 0 5	32. Registr	ar's Signa	ture	1)			
	Registı	al	G N MMC	LUUU PAR		10	A M.					

		-	_ ror	partment of Health and M ertificate of Death	lental Hygier	2000	01292
	Physicia	an	1. Decedent's Name (First, Middle, Last)			Day Year	3. Time of Death
	/Medic	al	FRANKLIN DAVID SIMPKINS 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	JANUARY	9 2006 4c. County of Death	1:06p ^M
	Examin	er	Chester River Hospital Center	Chestertown		Kent	
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Ye	9 Birthr	place (State or Foreign
L.	Director		217-36-0916		Feb 18 1		y1and
	land ow	}	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Many e-fsh	ctor	MD Kent Millir	ngton			1 ☐ Yes 2√2 No
	death with the Maryland ms 23a or 28e-f show	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	sath w		33465 Cypress Rd. 11 Marital Status 12. Was Decedent Ever in U.S. 1	21651	anifu Vas as Na	U.S.A.	can Indian
		Funeral	11. Marital Status 1 □ Never Married 2⊠ Married 1 □ Never Married 2⊠ Married 1 □ Never Married 2⊠ Married 1 □ Never Married 2⊠ Married 1 □ Never Married 2⊠ Married 1 □ Never Married 2⊠ Married	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	Rican, etc.)	Black, White,	etc.
3	ral', o	þ	3 ☐ Widowed 4 ☐ Divorced If Tes, Give Year or Dates: —1955	1 ☐ Yes 2 ☑ No Specify:		Specify: W	nite
15-0036	within 72 hours after ene. then "natural", or Ite re Medical Examina	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work	ing 16b	. Kind of Business/In	ndustry
7	withir ene. then	dwc	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired) Farmer		Farmin	a
פ	E A E E	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		
<u>o</u>	D 25 D	ToE	Olan Simpkins	Martha	Bell Pa	rsons	•
Mary				ailing Address (Street and Number or Rur			
	1 an Heall em 2 ther		20a. Method of Disposition 20b. Place of Di			Location - City or Te	
ē	Pages nent of int: If it		1 M Buriai 2 Ucremation 3 Unemoval from State	orematory or other place) ul'S Cemetery 1/	11/06	Chestert	own, MD.
Baltimore,	permit. Pages Department of Important: If it any injury or o			22. Name and Address of Facility Galena Funeral F 118 West Cross S	ome of S	Stephen	L Schaech
Ť.			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or beart failure. List only one cause on each line.				Approximate Interval Between
	Pnysician .		Immediate Cause (Final disease or condition Cardiac Ar	rest			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
		er	Sequentially list conditions, if any, leading to immediate b. Cardiac Ar Due to (or as a consequence of):	rythmia			
V	cuted nd ransit	Examiner		Infarction			
8760,	be executed sician and burial-transit	ai Ex	resulting in death) Last Due to (or as a consequence of):				
289	ficate physics the l	edicai	d	10-			
ŏ	eath certific attending p	In/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 Ectopic pregnancy		23d. Date of deliv	rery
O. B	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Me	in the past 12 months? 1	5 Other (specify)		Month	Day Year
1	res that the de signed by the a be detached	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	co use contribute to t	the cause of death?
Records,	w requires been sign should be				1 🗆 Yes	2 No 3 Pro	bably 4 Onknown
000	ne law re s has bee ge 2 sho	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
_	: The cate h	Соп			performed 1 ☐ Yes 2 ☐	death?	2 No
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ion	uttending death. ctor: Aft / the fun	atio	2 Accident investigation	ry Work? M 1 ☐ Yes 2 ☐ No			
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, of the desired physician of the des	eath occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as s and place, and due t	stated. to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
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1	8x1			N. DuPont Blvd.	Smyrna	, DE. 19	977
	St Regist	ate rar	31. Date filed (Month, Day, Year) 2. Registrar's Signature	ali			

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			Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
	Physicia /Medic		Porteous Smith	January January	5,2006 5:25PM
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	Funeral		Charlotte Hall Veterans Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) Charlotte Hall	St. Mary's 9. Birthplace (State or Foreign Country)
В	Director		186-18-6326 ¹ XM 2□F 88 Yrs.	Months Days Hours Min. (Month, Day, Y December	
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
	a-fsh	ctor	MD St. Mary's Charl	lotte Hall	1 ☐ Yes 2X No
	with th	Funeral Director	10e. Street and Number		. Citizen of What Country?
	ns 234	erai	29449 Charlotte Hall Road 11. Marital Status 12. Was Decedent Ever in U.S. 13	20622	USA 14. Race - American Indian,
9	after d	Fun	1 □ Never Married 2 □ Married 1 TVYes 2 □ No	3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or Items 23s or 28s-f show event. The Medical Evaning must be notified at	d by	Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: white
15	n "nat	plete	(Specify only highest grade completed) (Given the complete of	pedent's Usual Occupation ve kind of work done during most of working . DO NOT use retired)	b. Kind of Business/Industry
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aryl	s 1 and 2 should be f Heelth and Menta itsm 27 is marked other traumatic ev	2	unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	unknown iling Address (Street and Number or Rural Route Number, C	City or Town, State, Zip Code)
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altimore,	ges 1 au it of Hee If itsm or othe		The Danial 2 Doramation 5 Ditemoval nom State	rematory or other place)	c. Location - City or Town, State
Itim	permit. Pages Department of H Important: If its any injury or of			nd Veterans 1/18/06 Ch	eltenham,MD
Ba	Deparenti Deparenti Impo any ir		19and (Echala)	AREHART-ECHOLS FUNERAL	HOME, P.A.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respiratory arrest	Interval Between
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Box	the death certificate y the attending physiched for use as the l	Physician/M		3 □Ectopic pregnancy	23d. Date of delivery Month Day Year
o.	that the de led by the a detached f	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	5 ☐ Other (specify)	
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ord	w require been sig			1 □ Yes	2 No 3 Probably 4 Micrown
Vital Records,	has by	Completed		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
tal		e Co	25. Was case referred to edical		No 1 Yes 2 No
f∨i	S S	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	- Cther	ce 6 □Other (Specify)
n of			27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) 1 Injury	Work?	injury occurred
Division	deat deat ctor: / the	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,	M 1 Yes 2 No	et and Number or Rural Route Number.
Ö		Certi	4 Homicide determined building, etc. (Specify)	City or Town, S	
	To the Hospital or within 24 hours effet To the Funerel Dir completely filled in	edical (29a. Certifier (Check only (Ch	ath occurred at the time, date and place, and due to the causinvestigation, in my opinion, death occurred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complet	Med	one) and manner stated. 29b. Signature — d title of certifier	29c. License number 29d	Date signed (Month, Day, Year)
)	->-0	100	AM MOW T	00060120	1/6/06
	110		30. Name and address of person who completed cause of death (Item 23a) (Typ	investigation, in my opinion, death occurred at the time, date 29c. License number 29d DGG GO (ZO 19. Print) Pital Rd Prince Freder	ick, nD 20678
	Sta		A. Wall Hags shmn 100 Has 31. Date filed (Month, Day, Year) 32. Registrar's Signature	prior not prunce p	
	Registi		JAN 1 8 2006 Bosen # Good		
DI	MH 17 Boy 1/2	001	7 - 2000 / 100/1/200		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar U5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Leland Stewart Stonesifer **Physician** 11 2006 January 10:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 408 Oak Hill Court, T-4 Carroll County Westminster 5. Social Security Number If Under 1 Year | II Under 24 Hrs. 8. Date of Birth (Month, Day, Mar. 18 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Months Hours Min ^{Year)} 1930 1**X** M 2□ F 75 545-48-3866 Yrs. Mar. Director Maryland Usual Residence of Decedent the Maryland 10a State 10c. City. Town or Location 10h. County 10d. Inside City Limits 28a-f show fraumatic event, the Medical Exerciner roust by notified at 1 XYes 2 □ No Directo Maryland Carroll County Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 408 Oak Hill Court, T-4 21157 United States items 23a death Funerai 12. Was Decedent Ever in U.S.
Armed Forces? 1947—
1 X Yes 2 No 1947—
If Yes, Give 1062 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after a n and Mental Hygiene. Is marked other than "natural", or ite: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: white þ 1962 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) underground technician telecommunications 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar Leroy Stonesifer Sadie Wareheim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an Joan Dolores Stonesifer / wife 408 Oak Hill Court, T-4 Westminster, Md. 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Depertment of H
Important: If ite
eny injury or oti Jan. 12 1 ☐ Burial 2 XCremation 3 ☐ Removal Irom State Smithsburg, Maryland Smithsburg Crematorium 4 ☐ Donation 5 ☐ Other (Specify) 2006 22. Name and Address of Facility 21. Signature of Fugeral Service Licensee Skiles Funeral Home 136 East Baltimore Street Taneytown, Md. 21787 un 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 12 disease or condition resulting in death) Boyean /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine the ettending physicien and ched for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy signed by the ette in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 🗆 No 9 Linknown 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 🗆 No 3 Probably 4 Unknown certificete has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural 2 Accident njury 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25443 W. Muddleton 2006 8x1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John W. Middleton, M.D. 688 Poole Road Westminster, Maryland 21157 31. Date filed (Month, Day, Year) AN 1 8 2006 32. Registrar's Signature State Registrar

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	i general de la companya del companya del companya de la companya	. %	1. Decedent's Name (First, Middle, Last)							2. Date of D			3. Time of Death	
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	iand		10a. State 10b. County		10c. Cit	ty, Town or L	ocation.						10d. Inside City Limits	
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AMRVEY 0036	rs alt	by F	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	110		1 🗆 Yes	2 X No	Specify:			Specify:	White	
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an	d be ental	Be c	Harvey Sand	lers SR					71	nio M	7			
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ANDERS	s 1 and 2 should f Health and Men Item 27 is marke other traumatic				- - 1			•					1	
_	C W 14 F		Carolyn L. Spreche	i (Daugi	20b. F	Place of Disc	osition (Na	me of		Date	20c	Maryland Location - City or	21/83 Town State	
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S A Saltimore,	nit. Page ortant: If ortant: If Injury or		4 Donation 5 Other (Specify)			Cemete	ry			2006			, Maryland	
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			 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on 	ations that cause e cause on each l	d the deat line.	th. Do not er	nter the mo	de of dyin	ng, such as cardia	ic or respiratory	arrest,		Approximate Interval Between Onset and Death	
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	/Medical		resulting in death)	Due to (or as					1001-1					
	Examiner		Surpressibility Set monditions	tug PE	RTE	NSIDI	N						YEARS	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as			777							
	be executed ician and burial-transit	Examiner	that initiated events	PERS	SISTE	NTV	EGE	TATI	NE ST	ATS			3 yrs	
1, 0	exe	EX	resulting in death) Last	Due to (or as	s a consec	quence of):								
760	S 8	icai	d											
- R89	g ph as th						_				1			
∕~~×	eath certific: attending pl for use as t	2	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome								23d. Date of deli	very	
9 9	death e atte d for	ic a	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a			□Ectopic □ Other (s		<u> </u>		.	Month	Day Year	
20	it the deby the by the lached	hys	9 🗆 Unknown	9□ Unknown		- 221 111								
7	the ed de	Completed by Physician/Med	Part II. Other significant conditions con	tributing to death I	but not res	sulting in the	underlying	cause giv	en in Part I.	23e. Dio	tobacco	use contribute to	the cause of death?	
ords,	puires n sign	D D	CHRONIC OBSTRUC	TIUS P	ulmi	MARY	L DIS	EASE	5	10	Yes	2 □ No 3 S Pro	bably 4 Dunknown	
€ 8	w requir	lete	CONGESTIVE HEA	OT PA	HILLR	ς				24a. Wa	ıs an	24h Were au	topsy findings available	
He S	The lay ate has page 2	Ę	Corvaestion itch	ic i	100411					aut per	opsy formed?	prior to c death?	ompletion of cause of	
<u>a</u> ~			05.111				-			1 Tes		lo 1 🗆 Yes	2⊠ No	
%≅	ysician: Is certific director,	Be	25. Was case referred to medical examiner?	ospital:				Oth	er.	ath Check only				
20	Phys this	<u>۲</u>	1 ☐ Yes 2 No 27. Manner of Death	28a Date of Ini		ER/Outpatie 28b. Time		OA	Nursing	Home 5 ☐ Re: 28d. Describe		6 Other (Spec	ufy)	
n	ding Ph h. After th funeral	io	1 Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ay Year)	Injury		28c. Injur Wor	k? Yes 2⊡No	250. 2650120	3 11011 1113	dry occurred		
<u> S</u>	death. ctor: A y the fu	cal	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of In	de la	ama farm a			163 2 110	20f Location	(Ctenat)	and Number or Ru	- I D	
Division	Jor Atl after d Direct Jin by	Certification:	4 Homicide determined	building, e	tc. (Special	fy)	ireet, lacto	ry, onice		City or T	own, Sta	te)	rai Houte Number,	
18 -	spital or ours afte neral Dir filled in		200 Comilion	ining To the best			Ale							
1	Hos Fur Tely	edical	29a. Certifier 1 ☐ Cartifying Phys (Check only one) 2 ☐ Medical Examin	er: On the basis of and manner s	of examina	ation and/or i	nvestigatio	n, in my o	ne, cate and plac pinion, death occ	e, and due to thurred at the time	e cause(e, date a	s) and manner as nd place, and due	stated. to the cause(s)	
	within 2 To the	Med	29b. Signature and title of certifier	and mailler S	.u.ou.		20	c. Licens	e number		29H D	ate signed (Month	Day Year	
	5 3 E 8		Dom.	MD					2895					
			1/01/1						75		7	AN, 13,	2006	
			PAULINE DACES N	mpleted cause of	death (Iter	т 23а) (Туре			Pennsylvan	100				
	Aller and the con-		31. Date filed (Month, Day, Year)	32. Regist	trar's Sign	ature	н	agerst	own, AD 2	1742 -		- ENGLISH I		
	Sta Registi		IAN 1 8 2nns	Rea >	M	Social								

			i iouse i	State of Ma					-		-				
			1 - For State Registrar	State of Ma	uylanu		tificate of		iu ivieritai H		211116	012	96		
			Decedent's Name (First, Middle, Last,	1				Dodin	2. Date of	Reg. N Death	10.	3. Time of	f Death		
	Physici		Drema S. Smith						Janua)ay 2006	3:35	РМ		
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location of D			c. County of Deat		1		
	Examilia		Manorcare Nursing	Center of	Whea	ton	Silve	r Spring	g	M	lontgomer	У			
	Funeral		5. Social Security Number 6. Sec	7. Age	(In yrs. las	t birthday)	If Under 1 Yea Months Day		Hrs. 8. Date of Min. June	I		nplace (State ountry) Virgi	or Foreign		
L	Director		232 70 4123	M 21XF	37	Yrs.	WOTHIS Day	3 110013	June	4, 1	948 Wes	"Virgi	nia		
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation					10d. Inside C	ity Limits		
	daryl f sho	ō	Maryland Montgome	ry	Gait	nersb	urg						2 🗆 No		
	the 28e-	rect	10e. Street and Number				10f. Zip Code			10a. C	Citizen of What Co	untry?			
	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f show the Miscell Examiner must be molified at	Funeral Director	1 North Summit Dri	ve, #102			2087	7			ited Sta				
	death rms 2	nera		12. Was Decedent E Armed Forces?	ver in U.S.	13. V	Vas Decedent of	Hispanic Origin	? (Specify Yes or luerto Rican, etc.)		14. Race - Ame	rican Indian,			
ထွ	after or Ite		1 Never Married 2 Married	1 ☐ Yes 2 🔯N If Yes, Give			rYes, specnny Cu I∐ Yes 21⊠ N		uerto Hican, etc.)		Black, White	e, etc.			
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:				71			Specify:	√hite			
7	natu	Completed	15. Decedent's Edu (Specify only highest grad	cation completed)		16a. Deced (Give	lent's Usual Occ kind of work don	upation e during most of red)	working	16b.	Kind of Business/	ndustry			
2	withlir ane. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5-	+>		s Manage			Pot	tail Sale				
0 0	filed Hygir other ent, II	ပိ	17. Father's Name (First, Middle, Last)			Dares	Manage		Name (First, Midd			:8			
an	ld be ental ked c	To Be	Russell Smith						Robinson						
Maryland 21215-0036	shound M s mar umat	-	19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailin	g Address (Stree	et and Number o	r Rural Route Nun	ber, City	or Town, State, Z	ip Code)			
Ξ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The Marylan Institute of the Standard other then any injury of pages. Any injury of pages. Once.		Russell Price/ Son			2 Nor	rth Summ	it Aven	ue, # 3,	Gait	thersburg	g, MD 2	0877		
ore	# # # # # # # # # # # # # # # # # # #		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	emoval from State	20b. Plac	e of Disponetery, cren	sition (Name of natory or other pi Litan	ace) Ta	nuary 5,		Location - City or				
Baltimore,	Pag ment ent: 1		* 4 □ Donation 5 □ Other (Specify)	\sim	Me	remat	ory	2	006		xandria,	Virgin	nia		
<u>ga</u>	epart epart nport ny inj nce.		21. Signature of Funeral Fervice License	1	100689		. Name and Add	ress of Facility	DeVol F	inera	al Home,				
	40 E 8 9		1/m / U		thersburg	g, MD 2	0877								
L			23a Parti Erter the disease, or compli shock, or heart failure. List only or	cations that caused ne cause on each lin	the death. e.	Do not ente	er the mode of dy	ring, such as car	diac or respiratory	arrest,		Approximat Interval Bet	ween		
H	Priysician		Immediate Cause (Final disease or condition resulting in death)	Chronic	Obst	ructiv	ve Airwa	y Disea	se			Onset and I years	Death		
8	/Medical Examiner		Tooding in dealing	Due to (or as a	conseque	nce of):									
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ó	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a	conseque	nce of):									
1760,	± ≥ 5	icai		l											
89	death certificat e attending phy of for use as th	Med	IF FEMALE:												
. Box	ath ce trendi	an/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth			Ectopic pregnan	су		A.	23d. Date of deli				
o.	0 00 0	Physician/Med	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	time of deat	th 5□	Other (specify)				Month	Day \	Year		
<u>.</u>	Physicien: The law requires that the de this certificate has been signed by the a ral director, page 2 should be detached f	Phy	Part II. Other significant conditions cor	tributing to death bu	t not resulti	na in the ur	iderlying cause o	wen in Part I	23e Dio	tobacco	use contribute to	the cause of d	loath?		
Records,	signé d be	d by	Pickwickian Syn				idonying oddoo g	A COLL WILL IS		Yes a		babiy 4 🗆			
Ö	w require been sig	ete	Morbid Obesity						_						
Rec	The lay cate has page 2	Completed	- Holbid Obedity							s an opsy formed?	24b. Were aut prior to o death?	opsy findings a ompletion of ca	available ause of		
B	icien: Th certificate rector, pag	e Co	25. Was case referred to medical					00 Pt- /	1 ☐ Yes	2 X N		2 No			
5	Physicien: this certificatal director, I	o B	eyaminer?	lospital:	t 2∏E	R/Outnation	3 DOA 0		Death <i>Check on</i> ng Home 5 ☐ Re		6 Other (Case	(6 c)	100		
0	ding Phy h. After thi funeral	n: T	27. Manner of Death	28a. Date of Injury (Month, Day	/ 2	Bb. Time of	28c. Inj	ury at	28d. Describe	how inju	ury occurred	"Y)	_		
ō	Attending ir death. ector: After by the funer	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	1641)	Injury		ork?]Yes 2∐No							
Division of Vital	al or Attend after death Director: / d in by the f	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At hom	e, farm, stre	eet, factory, office	•	28f. Location City or T	(Street a	and Number or Rui	al Route Num	ber,		
	ital o rrs aft ral Di lled ir			1					//						
	To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in by	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	3er: On the basis of	examinatio	edge, death n and/or inv	occurred at the estigation, in my	time, date and pl opinion, death o	lace, and due to the	e cause(:	s) and manner as	stated. to the cause(s))		
	thin 2 the mple	Med	Unity .	and manner stat	led.			ise number			ate signed (Month				
			29b. Signature and title of certifier	->/ /w	/			0545			uary 3,				
•	3		30. Name and address of person who co		ath /lto= 0	Sal (Tunn 1					., .,				
			Godswill O. Okoji		•	, , , , ,	•	Avenue	Takoma F	ark	Marvlan	d 2091	2		
	Sta	te	31. Date filed (Month, Day, Year)	4				v cirue 9	Takoma I	ur K,	in y Lati	u 2091.			
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			1 - For State Registrar	State of Maryland	/ Depa		ealth and		ene 2005	01297
			Decedent's Name (First, Middle, Last)			imouto or E		2. Date of Death	. No. U U U	3. Time of Death
	Physicia		Mary Catherine	Spangler				January	7 2006	r
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Deal		4c. County of De	
	LAGITITI		10704 Oak Forest	Drive		Hage	rstown		Wash	nington
T	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birth		irthplace (State or Foreign Country)
	Director		219-14-8422	M 2X□F 81	Yrs.	Months Days	riouts will.	8. Date of Birth (Month, Day, Y Jan. 16, 19	924	Maryland
	pu s		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	cation				10d. Inside City Limits
	sho	ū								1 Tes 2XXVo
	the N	ect	Maryland Washing 10e. Street and Number	ton	Wı	l liamspor	<u>†</u>	100	. Citizen of What (
	with Sa or	by Funeral Director	15800 Clear Sprin	a Rd			795	,,,,	USA	•
	ns 23	era		12. Was Decedent Ever in U.S.	. 13. \			Specify Yes or No-		nerican Indian,
(0	ifter o	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 XNo		Was Decedent of Hi f Yes, specify Cuba		to Rican, etc.)	Black, Wh	nite, etc.
8	rai', o	by	3√Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify: V	Vhite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther then "natural", or Items 23a or 28a-f show ent, Ite Medical Exant not must be putified at	Completed	15. Decedent's Educ (Specify only highest grade	cation e completed)	16a. Deced	dent's Usual Occupa	ation furing most of wo	rkina 16	b. Kind of Busines	s/Industry
21	Aithin ne. han	id m	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired,)			
2	led w lygier har ti	Co	12			Homemak		(5: 14: 14-	Home	9
and	be fi	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, Ma		
ž	houtd d Mei marke matic	스	Frank L. Cooper 19a. Informant's Name/Relationship (Type	no Print)	10b Mailie	a Address /Ctmata	Hazel	Stockslagural Route Number, C		Tin Codel
Maryland	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked othar than "natural", or Items 23a or 28a-1 show any injury or othar traumatic event, Ital Medical Exantination in the political at one.		William S. Spangle					Hagersto	T. Continu	
ō,	Heal Heal tem S		20a. Method of Disposition	20b. Pla		sition (Name of natory or other place			c. Location · City of	
JOH.	ages ent of ht: if i		1 🗡 Burial 2 □ Cremation 3 □Re 1 4 □ Donation 5 □ Other (Specify)					1.2006 W	illiamsno	ort,Maryland
Baltimore,	nit. F		21. Signature of Juneral Service Lineage	and a		S borne Adies				, rynar y rand
m	Depar impor any ir		V vi M	1/2-	42	25 S. Con	ocochead	ue St.Wil	liamsport	.MD 21795
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	Pnysician		Immediate Cause (Final disease or condition	Blade	los	CANCEN	,			Onset and Death
	/Medical		resulting in death)	Due to (or as a conseque	ence of):					13/
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_	xecut and II-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
09	te be executed ysician and ie burial-transit	cal E			ŕ					
68760,			0							
Вох	death certifica e attending ph of for use as th	Z/W	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnand		Te			23d. Date of d	elivery
m	death e atte	icia	in the past 12 months?	1 Live birth 2 Fetal of 4 Pregnant at time of dea		IEctopic pregnancy Other (specify)			Month	Day Year
P.O.	The law requires that the site has been signed by the bage 2 should be detache	Physician/Med	9 Unknown	9Ll Unknown						
	es the	by	Part II. Other significant conditions con	tributing to death but not result	ing in the u	nderlying cause give	en in Part I.			to the cause of death?
ord	w require been si should b	ted						⊺	2 No 3 F	Probably 4 Minknown
Records,	has b	Completed						24a. Was an autopsy	prior to	autopsy findings available completion of cause of
alF	cate							performe 1 ☐ Yes 2 ☑	d2 death? No 1 ☐ Ye	
of Vital	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	ospital:		t 30 DOA Othe		ath (Check only one)		0 1 - 1
oţ	tending Physician: The leath. tor: After this certificate hathe funeral director, page	1: To	1 ☐ Yes 2 ☑ No	1 Inpatient 2 E	R/Outpatien 28b. Time of	T SO DOA	4 🗆 I dui Sili g i	lome 5 ☐ Residence 28d. Describe how		Son's home
on	Attending r death. actor: After	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury Work	? /es 2 □ No		.,.,	
Division	= 0 0 >	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hom	ne, farm, str	eet, factory, office				Rural Route Number,
Ö	s after s after at Dirac	Certification:	4 Holdicide	building, etc. (Specify)				City or Town, S	orare)	
	To the Hospital or At within 24 hours after or To the Funaral Dirac completely filled in by	Medicai	29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of my known ner: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the tim vestigation, in my op	e, date and place pinion, death occi	e, and due to the causurred at the time, date	se(s) and manner a and place, and du	as stated. ue to the cause(s)
	ro the vithin o the	Me	29b. Signature and title of certifier			29c. License	number	29d	. Date signed (Mor	nth, Dey, Year)
)	- > = 0		1 014			052	2323	4	1/11/0	/
			30. Name and address of person who con	mpleted cause of death (Item 2	23а) (Туре,				(- (
3H	1-3		Dy Wasien	1126	Opa	Court	14-	1. Md =	21740	
	Sta		31. Date filed (Month, Day, Year) JAN 11 20	32. Registrar's Signatu	re			•		
	Registr	ar	OWN IT SO	UU Been L	7. Dj.	re le				

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year STEADMAN Jon Curtis 6329 AM PIAN 0 08 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Western Maryland Hospital Center Washington Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) June 19,1935 If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) Hours 1⊠M 2□F Months Days 70 223-44-1246 Virginia Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Waynesboro Pennsylvania Franklin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 255 West Main Street 17268 U.S.A. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 - 120 carpenter shop manager retirement home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Isaac Franklin Steadman Helen Furr Bowman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 255 West Main Street, Waynesboro, Pennsylvania 1726 Gloria Steadman - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State January 10,2006 Mt. Jackson, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Mt. Jackson Cemetery 22. Name and Address of Fecility Minnich Funeral Home 21. Signatura of Funeral Service Licenses 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on eech line. Immediate Cause (Final disease or condition resulting in death) E Sophageal Cancer contribute to the cause of death? 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

<u>۾</u>

Completed

Funeral

Director

72 hours after death with the Maryland

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylar Deperment of Health and Mental Hygiene. Internation the state of the stream of the stre

Baltimore, Maryland 21215-0020

g physician and as the burial-transit attending p cete has been sig , page 2 should b

P

The law requires that the deeth certificate be executed

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical ۾ Completed After this certificate has To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be ို Certification:

Sequentially list conditions, any, leading to immediate ause. Enter Underlying	b. Allevocal	vo to Ca	vdiovoscale	y disease	154
Cause (Disease or injury hat initieted events esulting in death) Last	C. Due to (C	or as e consequence o	f):		
_	d				74
art II. Other significant conditions o	contributing to death but not res	sulting in the underlyin	g cause given in Pert I.	23b. Did tobacco use co	ntribute to the cause of d
				24a. Was en autopsy performed?	24b. Were autopsy findi available prior to completion of caus of death?
				1∐Yes 2QNo	1 ☐ Yes 2 ☐ No
5. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpatient 2 □	ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Ott	ner (Specify)
7. Manner of Death 1 SNeturat 5 Pending 2 Accident investigation		red			
3 Suicide 6 Could not be determined		ome, farm, street, fact	ory, office	28f. Location (Street and Number City or Town, State)	ber or Rural Route Number

SH-20

State Registrar

edicai

29a. Certifier

31. Date filed (Month, Day, Year)

20 60

JAN 09

29b. Signature end title of certifier

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29c. License number

052325

1500 Pennsylvania Avenue

Hagerstown, MD 21742

29d. Date signed (Month, Day, Year) 107/06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KHALID M. WA

SEEM

32. Registrar's Signature

porte

Name of the last			Stata Ragistrar		artment of Health and M rtificate of Death	Rag.	2000	01299
**************************************	Physici	an	1. Decedent's Name (First, Middle, Last)				Day Year	3. Time of Death
	/Medic	al	Arthur John Steinman 4a. Facility Name (If not institution, give street and num	harl	4b. City, Town, or Location of Death	January	10, 2006 4c. County of Death	11:15 P M
1.5	Examin	ier	St. Mary's Nursing Center		Leonardtown		St. Mary	3
4	Funeral	. 77	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthp	lace (State or Foreign
3 .	Director		220-05-0585 X ™ 2□F	84 Yrs.	Months Days Hours Min.	(Month, Day, Ye 8/17/192	21 Mary	
	p ,		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo				04 1-14-01-11-1
	ehov	2	Maryland St. Mary's	Californi			1	0d. Inside City Limits 1 ☐ Yes 2X No
	28e-f	Director	10e. Street and Number	Garriorni	10f. Zip Code	100	Citizen of What Cour	
	with or a	ā	45291 Elmbrook Drive		20619		nited State	•
	ne 23	Funeral	11. Marital Status 12. Was Dece	dent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Americ	an Indian,
9	or Ite		1 Never Married 2 Married 1 Yes, Giv.		If Yes, specify Cuban, Mexican, Pueno	Rican, etc.)	Black, White,	
21215-0036	4 within 72 hours after death with the Maryland Jiene. r then "natural", or Iteme 23a or 28e-1 ehow the Mydical Exama et musi te myllied at	dby	3 Widowed 4 Divorced Year or Da	tes:	1 ☐ Yes X ☐ No Specify:		Specify: Whi	_e
2	natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of work	ing 16t	o. Kind of Business/Inc	dustry
12	within ene. then "	m d	Elementary/Secondary (0-12) College (1-	4or 5+)	DO NOT use retired) ion Mechanic	пс	Governmen	
d 2	Hygid Hygid Sither	ပိ	17. Father's Name (First, Middle, Last)	Aviat		(First, Middle, Mai		IL
an	Mental I	To B	Arthur Steinman		Emma My	ers		
Maryland	S D E E	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or Rura	al Route Number, C	ity or Town, State, Zip	Code)
	is 1 and 2 of Health a itsm 27 is other trai		Barbara Robertson / Daug	hter 4963	Bramhope Ln. Elli	cott City	7, MD. 210	i3
ore			20a. Method of Disposition 1 ☐ Burial 2 【▼Cremation 3 ☐ Removal from 5	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place)	Date 200	c. Location - City or To	wn, State
Ē	Pages ment of 1		4 ☐ Donation 5 ☐ Other (Specify)	Brinsfiel	d-Echols Crem 1/13		narlotte Ha	
Baltimore,	permit. Page Department of Importent: If eny Injury or once.		21. Signature of Funeral Service Licensee		2. Name and Address of Facility Bri			
	au = a		Kyle S. Simons 23a. Part1. Enter the disease, or complications that ca		22955 Hollywood Rd		Itown, MD.	20650 Approximate
	/Medical Examiner	miner	Sequentially list conditions, if any, leading to immediate cause. Enter U-derly a Cause (Disease or injury	or as a consequence of):	rentar acesa	ent		Interval Between Onset and Death
.O. Box 68760,	at the death certificate be executed by the attending physicien and tached for use as the burial-transit	Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, out: 1 Live bi	ant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
<u>α</u>	The law requires that the ste hes been signed by the bage 2 should be detache		Part II. Other significant conditions contributing to de	ath but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the	e cause of death?
of Vital Records,	uires sign d be	d by	Domentia Chron	ic renal,	failure	1 ☐ Yes	2 □ No 3 □ Prob	ably 4 Unknown
00	w requir s been si should	Completed	Diverticulard	saw xon	al costs Drahal	2724a. Was an	24b. Were auto	osy findings available
æ	The lav	E	in all I a trope I	Hoperte	nam	autopsy performed	prior to cor death?	πρletion of cause of 2∭ No
<u>E</u>		a	25. Was case referred to medical	701	26. Place of Death	1 ☐ Yes 2 ☐	INO TO TOS	2)& NO
>	dis ys	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ In	npatient 2 ER/Outpatier	04		e 6 □Other (Specif)	·)
	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month	f Injury 28b. Time o	f 28c. Injury at Work?	28d. Describe how	injury occurred	
sio	Attending r death. ector: Alter by the fune	cati	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
Division		Certification:	determined 200. Flace	of Injury - At home, farm, sti ig, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	it and Number or Rura State)	l Route Number,
1	To the Hospitel or within 24 hours after To the Funerel Dii completely filled in	1 · F	29a. Certifier (X Certifying Physician: To the	best of my knowledge, deat	h occurred at the time, date and place,	and due to the serve	e/s) and manage as =	ated
	e Hospitel 24 hours e Funerel letely filled	edicai	(Check only 2 Medical Examiner: On the ba	sis of examination and/or in	vestigation, in my opinion, death occurr	ed at the time, date	and place, and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	2	29c. License number	29d.	Date signed (Month,	Dey, Year)
	. 1) La Cry	- my	D51738	1	/11/20	06
(, k		30. Name and address of person who completed cause KAE T. AUNG	24435 M	Print) PERVELL DEAN	RD. HOL	LYWOOD	MD 20636
	Sta Regist		31. Date filed (Month, Day, Year) 32, JAN 1 1 2006	egistrar's Signature	rede			

Physician
/Medical
Examiner

Director

Be Completed by Funeral

2

Funeral Director

with the Marylend or 28e-f show Injury or other treumatic event, the Medical Examiner must be notified at 23a permit. Pages 1 and 2 should be filed within 72 hours after deeth v Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a any injury or other treumatic event. The Madical Examilited must. once.

Baltimore, Maryland 21215-0036

Marie Sharp

Pnysician /Medical **Examiner**

Completed by Physician/Medical Examiner use as the burial-transit signed by the ar Be 은 this Certification: death.

To the Hospitel or Attending Physician: The law requires that the deeth certificate be executed within 24 hours efter death To the Funerel Director: completely filled in by the

Division of Vital Records, P.O. Box 68760,

Registrar					Cen	titicate c	r Dea	เเก	F	leg. N	o	10	01000	2
. Decedent's Name	(First, Middl	e, Last)							2. Date of Dea				3. Time of Death	1
MARIE	M. SH	ARP							Jan	8	ay 20	Year 06	10:45	ďΝ
a. Facility Name (/	f not institution	n, give street and nu	ımber)			4b. City, Town	n, or Locat	ion of Death		4	c. County	y of Death		
Genesis	Healt	chCare -	The	e Pine	s	E	asto	n			\mathbf{T}_{i}	albo	t	
. Social Security N	umber	6. Sex	7. Age	(In yrs. last birt	hday)	If Under 1 Ye		nder 24 Hrs.	8. Date of Birt	Von	el .		place (State or Fore	ign
218-16-90	45	1 □ M 2 F		80	rs.	Months Da	ys Hou	ırs Min.	oct 26,	ľ	25	MAR	YLAND	
Jsual Residence of														_
10a. State	10b. County			10c. City, Town	or Loc	cation							10d. Inside City Lim	
MD		TALBOT				EASTON							X Yes 2□	No
10e. Str <i>ee</i> t and Nu	mber					10f. Zip Cod	0			10g. C	itizen of	What Cou	intry?	
700 PC	RT ST.	, #100				2	1601					US	A	
11. Marital Status		12. Was Dec	edent E	ver in U.S.	13. V	Vas Decedent	of Hispanie	Origin? (Sp	pecify Yes or No- Rican, etc.)			ce - Ameri	ican Indian,	
1 Never Marr	ied 2□ Mar	Armed F	2 N	0	i	Yes X			o moan, otc.,					
3 Widowed	4 ☐ Divorced	If Yes, G Year or i	Dates:		'	LI THS ALI	NO Spe	спу:			Specia	y: WH	IITE	
/Saar	15. Deceder	nt's Education	1	16a.	Deced	ent's Usual Oc	cupation	most of wor	kina	16b.	Kind of B	Business/Ir	ndustry	
Elementary/Seco		College		•)	life. D	kind of work do OO NOT use re	tired)	modi or wo	9					
12			0		SI	CRETAR	Y			C	TAUC	r gov	ERNMENT	
17. Father's Name	(First, Middle,	Last)					18. N	fother's Nam	ne (First, Middle,	Maide	en Sumai	me)		
EARL MI	TCHELI						H	LDA A	NDREWS					
19a. Informant's N	ame/Relation:	ship (Type, Print)		19b.	Mailin	g Address (Str	eet and N	u <i>mber</i> or Ru	rai Route Numbe	r. City	or Town	, State, Zi	p Code)	
BONNIE	J. TUI	TLE/DAUGE	(TER	1 1	1231	O MUST	ARD S	ST., 0	RLANDO,	\mathbf{FL}	3283	37		
20a. Method of Dis	,					sition (Name o		1	Date	20c.	Location	- City or T	own, State	
1 X Burial 2 ¹ 4 □ Donation		3 □Removal from Specify)	State	SPRING				1-12	-2006	E	ASTO	N, MA	RYLAND	
21. Signature of Fi	ineral Service	Licensee			22	. Name and Ad	Idress of F	acility	-					
-		00 = 0 -							N & NEWN				HOME PA	
23a Part1 Enter	the disease, o	or complications that	caused	the death. Do r					EASTON,		J-ZI	201	Approximate	
shock, or hea Immediate Cause		t only one cause on	each line			16	1		102		/.	8 8 1	Interval Between Onset and Death	
disease or condition	on	a	1	prom	4	obyru	div	e pru	know	di	1500	ca	igans	
rooming in outer,		Due to	o (or as a	consequence	of):			1	/					
Requestially list of	nditions,	b			0									
if any, leading to it cause. Enter Und	ertyina .	Due to	o (or as a	consequence	Of):							-		
Cause (Disease of that initiated event	s	c	-,											
resulting in death)	Last	Due to	o (or as a	consequence	of):							-		
		d												
IF FEMALE:														-
23b. Was deceded			birth :	2 🗌 Fetal death	3□	Ectopic pregn	ancy					ate of deliv Ionth	very Day Year	
1 ☐ Yes 2	No	4☐ Pred 9☐ Unk		time of death	5 🗀	Other (specify	/)						,	
9 🗌 Unknowi			-		-		_		1		-			
		ions contributing to	,	t not resulting in	n the u	nderlying cause	given in f	Part I.					the cause of death	
	rbelis	melliti	41						1/2	es	2 🗆 No	3 ☐ Pro	bably 4 Unkno	wn

25. Was case referred to medical examiner?

24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Yes 26. Place of Death (Check only one)

Other: Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

32. Registrar's Signature

1 0 2006

1 Yes 2XNo

27 Manner of Death

1-Natural

2 Accident

3 Suicide

4 Homicide



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Medical

State Registra

000	3		For	State of M	laryland / Dep				~ < 4 4 4 5	01302				
			- State Registrar		Ce	rtificate of	Dealli	2. Date of Deat	eg. Nő.	3. Time of Death				
	Physicia	an l	1. Decedent's Name (First, Middle,					Month	Day Year					
	/Medic	al	Paul Wayne Sl 4a. Facility Name (If not institution,		·1	4h City Town o	Location of Death	JANUARY	1, 2006 4c. County of De					
	Examin	er	10755 MARYLAND	POINT ROAD	,	NANJEMOY			CHARLES					
	Funeral		o. ocolar ocolary	6. Sex 7. A 1 □ 7 2 □ F	ge (In yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day. Nov. 5	Year) 9. B	irthplace (State or Foreign Country)				
	Director		523-25-9226	X. E.	31 Yrs.			Nov. 5	, 19/4 M	[aryland				
	and w	ł	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits				
	Manyl	ō	MD Char	les	Nanje	emoy				1 ☐ Yes 2 No				
	288-	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What (Country?				
	3a ol		10575 Shore A	cres Rd.		20	662		USA					
	deet me	Funeral	11. Marital Status	12. Was Deceden Armed Forces	nt Ever in U.S. 13	. Was Decedent of It If Yes, specify Cub.	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- to Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.				
98	ges 1 end 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other treumatic event, the Madical Examiner must be collided.		1 ☐ Never Married 2 Marrie 3 ☐ Widowed 4 ☐ Divorced] No	1□Yes 2☐XNo	Specify:		Specify: W	Thite				
21215-0036	hours tural	Completed by	15. Decedent'		16a Dec	edent's Usual Occup	pation		16b. Kind of Busines	:s/Industry				
5	in 72 n na Nadic	piet	(Specify only highest	college (1-4o	life.	e kind of work done DO NOT use retire	during most of word)	rking						
212	within jiene. r than "	E	Elementary/Secondary (0-12)	College (1-40)	Aut	o Body			Automo	tive				
ğ	12 should be filed within "h and Mental Hygiene." 7 le marked other than "Ireumatic event, tha Mas	Bec	17. Father's Name (First, Middle, L					me (First, Middle,)				
Maryland	Venta Menta rrked	ToE	Wilson R.	Shifflett					Christy C					
lan	2 sho and 1	1	19a. Informant's Name/Relationsh			_			r, City or Town, State					
	1 end 2 Health tem 27 other tr	1 9	Meredith A. S	hifflett/	WITE LUD A		Acres		20c. Location - City					
ore	Pages 1 nent of H int: If ite iry or otl		20a. Method of Disposition Burial 2 Cremation	3 □Removal from Stat	te cemetery, cr	ematory or other pla								
Baltimore,	tmen tant:	1	4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service to	oecity)	ULa Dui	cham			Nanjemo	re. LaPlata				
Bal	permit. Page Department of Important: If eny Injury or once.		Uniel T.	A. MD 2064										
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus	ed the death. Do not e	nter the mode of dy	ng, such as cardia	c or respiratory arr	rest,	Approximate Interval Between Onset and Death				
40	Physician		Immediate Cause (Final disease or condition		a HERLD AM NEW THURIES									
	/Medical		resulting in death)		as a consequence of):									
П	Examiner	_	Sequentially list conditions,	b	as a consequence of):									
	ed sit	ine	fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Sua to for t	as a sor secusor wo cry									
	xecut and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or a	as a consequence of):									
8760,	icate be executed physicien and s the burial-transit	dicai E		d										
9	rtificat ng ph) as th	Medi	IF FEMALE:	_		-		550	- 1/2/2/2	V				
Box	death certifica e ettending ph d for use as tl	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	B Ectopic pregnand	;y		23d. Date of o Month	Day Year				
-	0 0 0	Completed by Physician/Mee	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant 9☐Unknowr		5 ☐ Other (specify) _								
P.0	requires thet the de een signed by the e nould be detached f	A-	Part II. Other significant condition	ons contributing to deat	h but not resulting in the	underlying cause g	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?				
Division of Vital Records,	uires sign Id be	d b						1 🗆 Y	/es 2 1 1 3 □	Probably 4 Unknown				
S	> 0 %	ete						24a. Was	an 24b. Were	autopsy findings available to completion of cause of				
Re	The law ate has b page 2 si	E G						autop perfor	rmed? death	13/				
tal	siclen: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of De	eath (Check only o						
<u> </u>	ysich is cer direct	To B	examiner? X□ Yes 2 □ No	Hospital: 1 Inp	atient 2 ☐ ER/Outpat	ient 3 DOA	her: 4 🗆 Nursing	Home 5 ☐ Resid		pecify) SCENE				
٥	Attending Physiclen: r death. ector: After this certifica by the funeral director,	Ę	27. Manner of Death 1 Natural 5 Pendin	28a. Date of I (Month,	njury Day Year) 28b. Time Injur	y Wo		_	now injury occurred	War man both				
<u>.</u>	Attendin death. ctor: Afr y the fur	aţ	2 Accident investig	gation - -	06 011	7 P	Yes 2 TO-No	-		vennuen				
<u>;</u> ≥	or Att	Certification:	3 Suicide 6 Could determ	ained 200. Place VI	Injury - At home, farm, , etc. (Specify)	street, factory, office)	City or Tox	vn, State)	Rural Route Number,				
	oltel c urs et gral D		COn Codding 45 Codding	ng Physician: To the be	RODDUM	ath occurred at the	time date and place	ce, and due to the	Cause(s) and manner	as stated.				
	To the Hospitel or At within 24 hours effer or To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 Certifyir (Check only Medical	Examiner: On the basi and manner	is of examination and/or	investigation, in my	opinion, death occ	curred at the time,	date and place, and	ade to the cause(s)				
	To the within 2 To the comple	M	29b. Signature and title of certifie	n 1.			nse number	1	29d. Date signed (M					
			Malline	The She	le ur	0	CME		JANUARY 1	, 4000				
0			30. Name and address of person	who completed cause			क्रमान्य क्रमान	PTMODE M	INDVI AND '	21 201				
	13		31. Date filed (Month, Day, Year)	1) - KOK		PENN STR	EEI, BAL	LIMOKE, M	IARYLAND,	41401				
	St Regist	ate trar	JAN C	4 2006	istrar's Signature	gover								

Physician

/Medical

Examiner

Funeral

Director

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or 28a-f the

Items 23a

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Hygiene.

1 and 2 should be Health and Mental

Baltimore,

marked other

99 nt of Health a t: If item 27 is y or other tra

Department of Important: If any injury or once.

traumatic event,

the Medical Enginings must be notified at

Director

Completed by Funeral

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by Physician/Medical Examiner

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Certification:

cal

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death

hours after

1	Priy /N Exa	ysician ledical aminer
Box 68760,	eath certificate be executed	attending physician and for use as the burial-transit

ed by the a detached f

signed by t

page 2 s

After

Director:

Records, P.O.

Division of Vital

Hospital or Attending Physician:

death.

after

within 24 hours a To the Funeral D

4 41

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ 1 1 6 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Bruce Francis Shepler 4:00 P.M JANUARY 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea April 28, 1 5. Social Security Number Birthplace (State or Foreign Country) Days 1**∑**M 2□F Months Hours Yrs. 164-30-8934 68 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 TYYes 2 □ No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 Elk Chase Drive 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1956 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 17 Yes 2 No 1956— If Yes, Give Year or Dates: 1960 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Automobile Elementary/Secondary (0-12) 12 College (1-4or 5+) Assembler Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leroy Shepler Olive Lemke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 Melbourne Boulevard, Elkton, Maryland 21921 Beulah G. Shupe/Fiancee 20b. Place of Disposition (Name of cometery, crematory or other place)
Gilpin Manor
Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition January 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12, 2006 Elkton, Maryland P.A. Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 21. Signatur of Funeral Service Licensee 20 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final END STAGE HEART FAILURE UNKNOWN disease or condition resulting in death) Due to (or as a consequence of): CHRONIC OBSTRUCTIVE PULMONARY DISEASE Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4XXUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🛣 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier. D52739 JANUARY 7, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESH SHANDELYA, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902 31. Date filed (Month, Day, Year) 32. Registrar's Signature

ORIGINAL

Registrar

JAN 2 0 2006

William J. Sheetz Unpend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-0229 State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar AKG Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 9. 2006 Year Physician 9:04 A M William John Sheetz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 24 Kent Road E1kton Cecil If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1XM 2□ F 1984 Delaware Director 222-70-3677 July | Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show ns 23a or 28a-f ehor must be notified at 1 ☐ Yes 2 🕱 No Director Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 24 Kent Road United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. the Madical Examiner 1 ☐ Yes 2 X No If Yes, Give Year or Dates: filed within 72 hours after 1 X Never Married 2 ☐ Married Maryland 21215-0036 6 1 ☐ Yes 2X No Specify: Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Assistant Manager Convenience Store t 2 should be filed to and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Mae Anderson Robert Douglas Sheetz 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 f Heelth item 27 I Dorothy Mae Sheetz/Mother 24 Kent Road, Elkton, Maryland 21921 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Vest Nottingham
Presbyterian Cemetery 13, 2006 0 1 MBurial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Colora, Maryland 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 elesi 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Mixed Drug (oxycodone, carisoprodol) intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Attending Physician: The law requires that the death certificate be executed physician and s the burlet-transli resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical as IF FEMALE: esn esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 □Wnknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1

Yes 2

No 24a. Was an 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA |

28a. Date of Injury | DI | 28b. Time of Injury | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Company | Comp Other: 4 Nursing Home 5 Residence 6 Other (Specify) at SCENE 1 (XYes 2 □ No ٩ this 28d. Describe how injury occurred unk 27. Manner of Death Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2(TX)No 8:30 A 2 Accident 1/9/2006 after death Director: d in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 Kent Rd 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Found in residence Elkton, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. January 10, 2006 death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 0

32. Begistrar's Signaturb

2006

111 Penn Street, Baltimore, Maryland

OFM 06-00146 Tiakeshia Thompson

			For State	State	of Marylan	d / Depa	artment of F	lealth and N			06	01305
			Registrer 1. Decedent's Name (First, Middle	, Last)			timouto or	Dough	2. Date of Death			3. Time of Death
	Physici		Tiakeshia Rene	e Thomas	on				January	06.	2006	07:50 A M
}	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, o	r Location of Death		4c. Count		01.50 A
		ŭ.	27430 Point Loc	kout Roa	d		L	oveville		St.	Mary	¹s
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			lace (State or Foreign
	Director]	220-27-2347	1 L M 2 201 F	15	5 Yrs.			March 01,		Mary]	
	and	1	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				1	0d. Inside City Limits
	Manyl 1 sho	ō	Maryland Saint	Mary's		Ob a w I a s	II-11					1 Yes 2 No
	28a	Director	10e. Street and Number	rialy S		القلا القاال	tte Hall 10f. Zip Code		10	g. Citizen of	What Cour	ntry?
	Mit 3a o		28814 Thompson	Corner R	load		20	622		USA		
	deep E	Funeral	11. Marital Status		andost Cuncis II	.S. 13.	Was Decedent of H	dispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Ra	ce - Americ	
9	be filed within 72 hours after deeth with the Maryland ital Hygiene. Id other then "natural", or items 23e or 28e-f show other then "natural", or items 21e notified at event, the Madical Exertine rotal be notified at		1 Never Married 2 Marr	ied 1 ☐ Yes	2 🔼 No		1 ☐ Yes 2 X No	Specify:	7 110211, 010.7		tv: Bla	
ë	ural',	d by	3 Widowed 4 Divorced	Year or	Dates:	16- 8						
Maryland 21215-0036	n 72 "nat	Completed	15. Deceden (Specify only highes	st grade completed	·	(Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of world)	king	6b. Kind of E	susiness/in	dustry
12	iene.	E O	Elementary/Secondary (0-12)	College	(1-4or 5+)		Student			ublic	Schoo	1
2	filed I Hyg other	Be C	17. Father's Name (First, Middle,	Last)					ne (First, Middle, N			7.4.
<u>a</u>	uld be Aenta rked tlc ev	To B	Lawrence Alexan	nder Thom	pson			Bonnie G	ross			
an	sho and h		19a. Informant's Name/Relations				-	and Number or Ru		-	-	
≥.	and and a selth		Lawrence Alexander	Thompson /		_		Lane, For				
ore	ges 1 If ite		20a. Method of Disposition 1 Burial 2 □ Cremation	3 Removal from	n State	cemetery, cre	osition (Name of matory or other pla	ce)		20c. Location	- City or To	own, State
altimore,	tmen tant:		4 □Donation 5 □ Other (S	//	Que		eace Cemete		3, 2006	Helen,	Mary	land
Ba	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene. Important: If item 27 Is marked other then "naturat", or items 23a or 28a-f show any injury or other traumatic event, the Marical Exh. itier must be notified at ODGs.		21. Service of Funeral Service	Hard	liner	2	2. Name and Addre Mattingley P.O. Box 2	ess of Facility G-Gardiner F 170, Leonard	uneral Hom	e, P.A.		
			23a. Part1 Enter the disease, or shock, or heart failure. List	complications that	t caused the deat	th. Do not en						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ihe	- h	JURIE	5					Onset and Death
	/Medical		resulting in death)	d	o (or as a conseq							
П	Examiner		Sequentially list conditions,	b								
	pe tist	Jine	Sequentially list conditions, if any leaving to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a cons	uence of):						
_6	execut n end al-trar	Examiner	that initiated events resulting in death) Last	c. Due to	o (or as a conseq	quence of):						
8760,	cate be executed physicien end ; the burial-transit	dicai E		d								
9	rtificat ng phy as th	Medi	IC COM C	1								
Вох	th cer tendir rr use	an/h	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna		DEctopic pregnanc	v		1	ate of delive	•
0	The law requires that the death certificate has been signed by the attending I bage 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pre	gnant at time of d	death 5[Other (specify)			M	onth	Day Year
<u>a</u> .	hat th ad by detacl	Phy	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the L	inderlying cause giv	ven in Part I	23e. Did tob	acco use con	ntribute to the	he cause of death?
Vital Records,	uires tha signed Id be del	d by		•			, , , , , , ,		1 □ Ye	s 2 No	3 Prob	oably 4 []Unknown
Ö	w requir been si should	lete							24a. Was ar	24b	Were auto	ppsy findings available
Re	The law le has I	Completed							autops:	ned?	prior to co death?	mpletion of cause of
ta		a)	25. Was case referred to medica					26. Place of Dea	1 Ves 2 th (Check only one	!□ No e)	170 165	2 No
	Physician: r this certific ral director,	To B	examiner? 1∭Yes 2 ☐ No	Hospital: 1	Inpatient 2] ER/Outpatie	nt 3 DOA		ome 5 Reside		her (Specif	SCENE
0	ng Pt Iter th		27. Manner of Death 1 □Natural 5 □ Pendir	/8.4.	te of Injury onth, Day Year)	28b. Time o	Wo	ry at	28d. Describe ho	w injury occu	irred	. Bus
Sio	Attending it death.	catio	2 Accident investi	gation (6-06	739		Yes 2 No				LISIONWITH
Division of	or Atl	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	286. Pla	Iding, etc. (Speci	fy)	reet, factory, office		28f. Location (Sti City or Town	, State)		
	pital ours a eral [29a. Certifier 1 ☐ Certifyii	no Physician: To I		owledge deal	th coourad at the ti	me, date and place				revirce MD
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: Alter th completely filled in by the funeral	edical		Examiner: On the	basis of examina anner stated.	ation and/or in	nvestigation, in my	opinion, death occu	rred at the time, da	ate and place	, and due to	o the cause(s)
	withig To the	ž	29b. Signature and title of certifie	r 1.			29c. Licens	se number	29	d. Date sign	ed (Month,	Day, Year)
			Mayrie	The y	rell			O.C.M.E.	Ja	anuary	07, 2	2006
			30. Name and address of person	A 14	use of death (Ite			ceet, Bal	timore. N	(arv] ar	nd 212	201
		ate	31. Date filed (Month, Day, Year		Registrar's Sign		ne de		- , ~	J		
	Regist	rar	JAN 1	2000	ر سينې	A 14	ar all					

			T = For State Registrar	State of Maryland		rtment of H			giene 006	01306
	Physici /Medic Examin	cal	Decedent's Name (First, Middle, Last) Aa. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death	2. Date of Dea Month	04 200 6 4c. County of Death	4
	Funeral Director		5. Social Security Number 6. Sex 216 18 0739	Seneral Hosp M 2 F 7. Age (In yrs. Ia: 84		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day June 12	h Howa y, Year) 9. Birth Cor 2, 1921 Vi	rd place (State or Foreign intry) Cginia
	er death with the Maryland tems 23a or 28a-t show her must be notified at	Funeral Director		E11 2. Was Decedent Ever in U.S. Armed Forces?	icott	City 10f. Zip Code 21042	spanic Origin? (Spe n, Mexican, Puerto		10g. Citizen of What Col United St 14. Race - Amel Black, White	cates
11 Z 1 Z 1	d be filed within 72 hours after death with the Marylan and Hygienes. And Hygienes death with the medical Examinar must be notified at a event, the Medical Examinar must be notified at	Be Completed by	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Ezekiel Testerman	1 XYes, 2 No If Yes, Give Year or Dates: 1942— sation completed) College (1-4or 5+)	45 16a. Deced	ent's Usual Occupa kind of work done do NOT use retired,	Specify: ation furing most of worki	ng a (First, Middle,	Specify: Wh: 16b. Kind of Business/I Juvenile Corrections	ite Industry
ž Ž	ges 1 and 2 should be it of Heelth and Mental if tem 27 is marked or other treumatic ev	To	19a. Informant's Name/Relationship (Tyx) Jean L. Testerman/V 20a. Method of Disposition 1 Burial 2 Cremation 3 Re	Vife 20b. Pla	3634	g Address (Street a	and Number or Rura	I Route Numbe	or, City or Town, State, Z. City, MD 23	L042
Dallimor	permit. Pages Department of I Importent: If its any injury or o		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Ste	rling 4 ²²	Cemetery Name and Addres	1-10-	ry H. V	Sterling, V Vitzke's Far Licott City,	nily FH Inc.
	Certificate be executed from the private as the buriat-transit assets the private as the private	al Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lister of the Cause) that initiated events resulting in death) Last	Due to (or as a conseque	Do not enter lia nnce of):					Approximate Interval Batween Onset and Death
í	death certifi e attending i od for use as	hysiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Bc. If yes, outcome of pregnand 1 Live birth 2 Fetal d 4 Pregnant at time of dea 9 Unknown	leath 3 🗆	Ectopic pregnancy Other (specify)	NI	'A	23d. Date of deline Month	very Day Year
colds, r	requires that the been signed by th should be detache	ompleted by P	Part II. Other significant conditions con Parkin Son's dementia		ing in the ur	derlying cause give	n in Part I.	1 🗆 Y		bably 4 Unknown
ב	The lar	Be Compl	25. Was case referred to medical examiner?				26. Place of Death		sy prior to condeath? 2 No 1 Yes	opsy findings available ompletion of cause of
5	Phys this ral dii	Certification; To E	1 Yes 2 No H		R/Outpatient 8b. Time of Injury	28c. Injury Work M 1 🗀 Y	at ? /es 2 \(\subseteq No	28d. Describe h	lence 6 Other (Speciow injury occurred	
2	To the Hospitel or Attending within 24 hours after death. To the Funeret Director: After completely filled in by the funer	edical Certif	4 Homicide determined 29a. Certifier 1 Certifying Phys (Check only one)	building, etc. (Specify) icien: To the best of my knowler: On the basis of examinatio and manner stated.	edge, death	occurred at the tim	e date and place	City or Tow	n, State)	stated
		Me	29b. Signature and title of certifier	100	ı.D.		5653		29d. Date signed (Month)	
) @	∂- Sta		31. Date filed (Month, Day, Year)	mpleted cause of death (Item 2 180 Hickory 32. Rustrar's Signatu	Rider	ge Rd,	Colum	sia,	MD 2104	-4
	Registi	rar	JAN 0 6 20	106 Alaever	J. A	one				

Gary Thompson 06-00171

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Unpend item#23a,2/,28a-f,penff,052,2/2/00 III. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** THOMPSON GARY January 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Camp Springs
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Malcolm Grow Hospital Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 **∑**M 2 □ F Director 579-82-5507 41 June 29 1964 Wash., DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other then "natural", or iteme 23a or 28a-f ehow vent, the Madical Examinar must be notified at Yes 2 No Directo D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 607 Gresham Place, N.W. 20001 United States death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: δ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education of Heelth and Mental Hygitem 27 is marked other other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Randolph Codett Joycelyn Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2:
Department of Heelth ar
Important: If Item 27 le
eny injury or other treu 607 Greshan Place, N.W. Joycelyn Thompson/Mother Wash., DC 20001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 2 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery 1-13-05 Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Capitol Mortuary, Inc. raion Cly 1425 Maryland Ave., NE Wash., DC 20002 23a. Part 1. Enter the disease, or complications that cause of the death. On the enter the mode of dying, such as cardiac or respiratory arrest shock, or heart lailure. List grily one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cocaine Intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ cate has been sign page 2 should be 2 No 3 Probably 4 Unknown 1 TYes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No this certificate has 1 Yes 2 🗆 No 25. Was case referred to medical He 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 XYes 2 □ No 28b. Time of Fnd 28c. Injury at Work? 28a. Date of Injury Fnd (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred unk After Certification: 1 Natural 5 Pending 6:15 A M 1/7/06 1 Yes 2 No investigation 2 Accident efter death Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Bural Route Number, City or Town, State) 5151A11entown Road filled in by 4 Homicide Parking Lot Camp Springs, MD To the Hospital within 24 hours el 1 Certifying Physicien: To the best ol my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ical 29a. Certifier completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signat@re and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OMmite OCME January 8, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOREL MARGARITA 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) . Registrar's Signature State JAN 1 2 2006

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Hobert William Tolley January 3 2006 4:00 p M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Chesapeake Woods Center Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**⊠**M 2□ F Days Hours Yrs. Director 214-07-8363 97 1908 June 10, Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mantal Hyglene.
Is marked other then "neturel", or Items 23a or 28a-f show 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits treumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Completed by Funeral Director Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 114 Willis Street 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: white 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) store manager 11 hardware permit. Pages 1 and 2 should be filed.
Department of Health and Mental important: If Item 27 is many injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Andrew Tolley Flora Booze 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert W. Tolley 5955 Indian Quarter Rd., Cambridge, MD son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Old Trinity Churchyard 1/7/06 Church Creek, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signatur of Funeral Servicensee 700 Locust St., Cambridge, MD Lery 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician congestive heart disease or condition resulting in death) /Medical Examiner obstructive pulmonary disage 3 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit coronary attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 Other (specify) detached 9 Unknown 9 Unknown 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records. page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑No Other: 4 Jursing Home 5 Residence 6 Other (Specify) Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the for investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 40059973 near 100 Bramble St, Cambridge, completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day Ye

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dev Year VICHOLAS 6:0 3 2006 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death ADVE KOCKVILLE MONTGOMERY If Under 24 Hrs. 6. Sex 1X M 2□ F If Under 1 Year 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Days Months Yrs NONE MARYLANI 03 Usual Residence of Decedent 10a. Stete 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 □ No NONTGOMER 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 2086 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1□Yes 21√No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Detes: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) IHOMP. DENISE 1 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) CLUB TSHTON. SHTON MD 2086 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 02-03-06 ORGANTOWN 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MEDICAL ENER GROUET DUENIST Marcel Part1. Enter the disease, or complication shock, or heart failure. List only one or at caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest on each line. Immediate Ceuse (Final disease or condition resulting in death) MONA Due to (or es e consequence of): ONAN Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to foras e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed?

Physician /Medical Examiner

injury or other

Physician

/Medical

Examiner

Director

Funeral

Be Completed by

Funeral

Director

7 is marked other than "natural", or frams 23s or 28s-f show traumatic avent, the Modical Examiner must be notified at

permit. Peges 1 end 2 should be filled within 72 hours effer or Depertment of Health end Mentel Hyglene. mportant: If item 27 is marked other then "natural", or its

Baltimore, Maryland 21215-0036

death with the Merylend

igned by the ettending physicien end be detached for use es the bunel-trensit filled in by the funeral director, pege 2 should

The law requires thet the deeth certificate be execu

After this certificete hes

Director:

24 hours

within 24 hou To the Funer completely fil

Medical

State

Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760.

Physician/Medical Examiner þ Completed Be Certification: To

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

2 0 No

5 ☐ Residence 6 ☐ Other (Specify)

26	Place of Death	(Check of	nly one)

1 🗆 Yes	2□ No
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25. Was case referred to medical examiner? 1 ☐ Yes 2 No

Hospital: 1 Inpatient Date of Injury (Month, Day 5 Pending investigation

2 ER/Outpatient 28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3□ DOA 28c. Injury at Work?

4 ☐ Nursing Home

2 □ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier

27. Manner of Death

1 Naturel
2 Accident

3 Suicide

4 | Homicide

Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

Other:

1 TYes

29b. Signature and title of certifie

6 Could not be determined

29c. License number

29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

CENTER DR. KOCKVITTE MB MEDICAL

ea 9 31. Dete filed (Month, Day, Yeer)

32. Registrer's Signature

Registrar DHMH 16 Rev 6/95

ORIGINAL

			1 - For Stata Registrar	State of Mai	ryland /		rtment of F		ınd Men		ene 0 0 (6 0	1310	
N	5 4		Decedent's Name (First, Middle, Las	st)						ate of Death			3. Time of Death	
	Physici /Medio		Stephen Lawrenc	e Vallandi	ngham.	Jr.				_{Month} nuary	•	Yeer 2006	4:27 p	N
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, o	r Location of			4c. County of			
	3 34	it .	22398 Budds Cr					rdtown			St. M	lary's	3	
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last b		If Under 1 Year Months Days	If Under 2 Hours	Min. (Date of Birth Month, Day,)	(ear)	Country		חן
***	Director		214-14-4598 Usual Residence of Decedent		86	Yrs.			8-	22-191	9	Mar	y1and	
	land wo		10a. State 10b. County		10c. City, Tov	wn or Loca	ation					100	d. Inside City Limit	s
	Mary	ţō	MD St. Ma	arv's	Leor	nardt	own						1 ☐ Yes 2 🖀 N	0
	r 28a	Director	10e. Street and Number	<u> </u>	Beer	ial ac	10f. Zip Code			100	g. Citizen of W	hat Countr	y?	
	23a o	a D	22398 Budds Cre	ek Road			2065	50			United	Stat	es	
	deat	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. W	as Decedent of H Yes, specify Cuba	lispanic Orig	gin? (Specify	Yes or No-		- American		
ထ္ထ	or Its		1 Never Married 2 Married	1 Yes 2 No			Yes 2 No	Specify:	, i dello riical	11, 610.)	Specify:	, White, et	C.	
8	be filed within 72 hours after death with the Maryland stal Hygiene. de other than "natural", or Itams 23e or 28e-f show event, the Modical Extrainer must be mulliad at	Completed by	3 Widowed 4 □ Divorced	Year or Dates:								Wh	ite	
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12	within ene. then "	d mc	Elementary/Secondary (0-12)	College (1-4or 5+))		armer	-/		_	gricult			
2	Hygi Hygi Sther		17. Father's Name (First, Middle, Last)			<u>r</u>	armer	18. Mother	r's Name (Fir		gi iden Sumame			
an	id be ental ked o	To Be	Stephen Lawrenc	ce Vallandi	.ngham			Ju1	ia Mar	ie Bow	les			
ary	2 should be and Mental 1 s marked c	-	19a. Informant's Name/Relationship (1	Type, Print)	19	b. Mailing	Address (Street	and Numbe	r or Rural Ro	ute Number, (City or Town, S	State, Zip C	ode)	
Σ	s 1 and 2 should f Heelth and Men Item 27 is marke other traumatic		Stephen G. Valla	ndingham/So	n 2	27605	Baptist	Chur	ch Roa	d, Mec	hanicsv	ville	, MD 2065	59
Baltimore, Maryland 21215-0036	permit. Pages 1 and Department of Heelth importent; If Item 27 eny injury or other t ance.		20a. Method of Disposition	Domewal from State	20b. Place cemet	of Disposi	ition (Name of atory or other place	(e)	Date	20	c. Location - C	City or Tow	n, State	
Ē	Page nent ant; if		1 ■ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		Valla	ndin	gham Cem	1.	1-10-2	006 C	lements	s, Mar	ryland	
alt	permit. Departrimporte		21. Signature of Juneral Service Licen			22.	Name and Addre	ss of Facility	Brins	field	Funera]	LHome	P.A.	
<u> </u>	20559		Edward N. Brinsfi		400052		2955 Но1					ı, MD	20650	
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the one cause on each line	he death. Do	not enter	the mode of dyir	ng, such as o	cardiac or res	piratory arres	t,	1	Approximate nterval Between	
	Physician		Immediate Cause (Final disease or condition	a	LUN	19	(and	184				~ (Onset and Death	, (
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	e of):							1 - 41)
	Lammer	_	Sequentially list conditions,	b		5000								
	pe tis	Examiner	day, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	3 (01)								
_	and and II-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a	consequence	a of):								
8760,	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit				, , , , , , , , , , , , , , , , , , , ,	,-								
687	ficate phys	edicai		_ d.								-	THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TO THE PERSON NAMED IN COLUMN T	
	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							23d Date	of delivery	,	
Вох	death a atte	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti			ctopic pregnancy Other (specify)				Mont		ay Year	11
0	by the deriached	hys	9 Unknown	9□ Unknown										
σ,	res tha signed be det	by P	Part II. Other significant conditions of	ontributing to death but	not resulting	in the und	derlying cause giv	en in Part I.		23e. Did toba	cco use contri	bute to the	cause of death?	
Records,	w require been sig should b									1 🗌 Yes	2 □ No 3	3 Probab	bly 4 □Unknow	n
သွ	e law re has be je 2 sho	Completed		OPD						24a. Was an	24b. W	ere autops	sy findings availabl	е
ž	The ate har page	E								autopsy performe 1 ☐ Yes 21	ed? de	eath?	pletion of cause of X No	
Vital	Attending Physician: Th r death. sctor: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?		101	1000		26. Place		eck only one)			il.	
<u></u>	Physic this ce al dire	To	1 ☐ Yes 200 No	Hospital: 1 Inpatient		outpatient	3 DOA Oth	er: 4 🗌 Nur	rsing Home	5 Residen	ce 6 Othe	r (Specify)		
u u	ng Ph Mer th Ineral	iio	27. Manner of Death Solution	28a. Date of Injury (Month, Day	Year) 28b.	Time of Injury	28c. Injur Wor	y at k?	28d.	Describe how	injury occurre	d		
sio	ttending F death. tor: After the funer	cati	2 Accident investigation 3 Suicide 6 Could not be	a				Yes 2□N						
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	e Hospital 24 hours e Funeral l letely filled	edical	(Check only 2 Medical Exam	ysician: To the best of niner: On the basis of e and manner state	examination a	ge, death ind/or inve	estigation, in my o	ne, date and pinion, deat	n place, and o	the time, dat	ise(s) and man e and place, ar	iner as stat nd due to ti	ied. ne cause(s)	
	To the within 2. To the complet	Me	29b. Signature and title of certifier				29c. Licens	e number		290	d. Date signed	(Month, Di	ay, Year)	_
	⊢s⊢ō		· K	PN _ I	MD			36	206		01/9/0	16		
•			30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type, P	rint)	, ,			0		-0636	
			Kin		· ML		A !	70/	1400	1000	1 m	00 2	0636	
46	Sta		31. Date filed (Month, Day, Year)	32 Registrar	's Signature	has								
	Regist	rar	JAN 1 0 20	06	. 1	do	adl a							- 1

			For State Ragistrar	State of	Marylar		artmer rtifica			nd Me		giene Reg. No. 006	01311
	Physicia	an	1. Decedent's Name (First, Middle, L	ast)						2	Date of Dea Month	ath Day Year	3. Time of Death
	/Medic	al	Charles Lewis 4a. Facility Name (If not institution, gr				4h Cih	Town or	Location of		January	y 1, 2006 4c. County of Dea	5:30 A. M
	Examin	er	Calvert Memoria				/		reder			Calvert	
# 5 E	Funeral	-		Sex 7		last birthday)		r 1 Year	If Under 2		. Date of Birtl (Month, Day		thplace (State or Foreign
ječ.	Director		137-12-6653	1 M 2□F	88	Yrs.	MONTHS	Days	110013		ec. 21		Jersey
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
	Mary f aho	ō	Maryland Calvert		Lus	bu							1 ☐ Yes 2 No
	within 72 hours after death with the Maryland one. than "natural", or itama 23a or 28a-f ahow ra Madical Exacilmat must be notilliad a	Funeral Directo	10e. Street and Number	•	LLUS	Dy	10f. Zi	Code				10g. Citizen of What C	ountry?
	th wit	alD	251 Cove Drive				206	57				United St	ates
	tama tama	nue	11. Marital Status	12. Was Deced Armed For	ces?	J.S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Orig n, Mexican,	in? (Speci , Puerto Ric	fy Yes or No- can, etc.)	14. Race - Am Black, Whi	
36	rs afte	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	If You Give	2□No tes:WW I	т	1 🗆 Yes	2 No	Specify:			Specify: Tath	ite
5-0036	2 hou		15. Decedent's	Education	WW I	16a. Dece	dent's Usu	al Occupa	ation	-4		16b. Kind of Business	
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and	ould be filed within Mental Hygiene. Marked other than satic avant, ine Mentic avant, ine Mentic avant, ine Mentic avant, ine Mentic avant, ine Mentic avant, ine Mentic avant, ine Mentic avant, ine Mentic avant, ine Men	Be	17. Father's Name (First, Middle, Las	sr)							Thomp	Maiden Surname)	
Maryland 2121	should ind Men in marke umatic	ှင	Harry Van Dyke 19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Addres	s (Street a				or, City or Town, State,	Zip Code)
	and 2 sealth ar n 27 la		Elizabeth E. Van		fe)		-					nd 20657	
altimore,	of Head		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	MDomoval from S	1	Place of Dispo	osition (Na matory or	me of other place	θ)	Dat	0	20c. Location - City of	Town, State
Ē	Pages ment of I ant: If its ury or o		4 □ Donation 5 □ Other (Spec		Me							Alexandria	
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: (I tiam 27 ia marked other than "natural", or itama 23a or 28a-f ahow any interpretant in the notified at any intry or other traumatic avent, the Modical Exaction cannot be notified at any.		21. Signature of Funeral Service Lic	ensee								neral Home epublic, Mary	•
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	v one cause on ea	ch line.						espiratory ar	rest,	Approximate Interval Between Onset and Death
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	icate be executed physician and sthe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (c		Priph	era	2	OC.	اساء	au	diseos	0
8760,	cian a		resulting in death) Last	Due to (d	or as a conse	quencelof):							
87(physic the b	dica	,	d									
O. Box 6	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Fet ant at time of	al death 3	⊒Ectopic p ⊒ Other (s					23d. Date of de Month	livery Day Year
0.	s that the	by Ph	Part II. Other significant conditions	contributing to de	ath but not re	sulting in the L	ınderlying	cause give	en in Part I.		23e. Did to	obacco use contribute t	o the cause of death?
ırds	w requires t been signe should be	ed t									1 🗆 Y	res te No 3□P	robably 4 Unknown
Division of Vital Records,	2 88	Completed										osy prior to death?	utopsy findings available completion of cause of
ita	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?						26. Place	of Death (Check only o		
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on	Attending F r death. ector: After by the funer	tlon:	27. Manper of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat		n, Day Year)	28b. Time o	M	28c. Injury Work	γaτ ⟨? Yes 2 □ h		a. Describe r	now injury occurred	
Divisi	5 # 5 E	Certification:	3 Suicide 4 Homicide 6 Could not determine	289. Place	of Injury - At t g, etc. (Spec	nome, farm, st	reet, facto	ry, office		28	f. Location (5 City or Tox	Street and Number or R vn, State)	tural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical (29a. Certifier Certifying (Check only one)	Physician: To the aminer: On the ba and mann	sis of examin	owledge, deal ation and/or in	th occurred ivestigatio	at the tim	ne, date and pinion, deat	d place, an th occurred	d due to the d at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier N. M.	edon	0	MD	29	c. License	number 006	063	38	29d. Date signed (Mon	th, Dey, Year)
1	4+1		30. Name and address of person wh	no completed cause	of death (Ite	m 23a) (Type,	Print)	N H.	ENDO	WEA K	2000	PRINCE I	-REDERICE 18.
14 /2 10 /2	Sta Regist		31. Date filed (Month, Day, Year)	- 4 2006	egistrar's Sign	ature	1						

		-	For State Registrar	State of Marylan		artment <i>tificate</i>			nd Me		giene Rog. No.	16	0 3	2
į.	Physicia	_	1. Decedent's Name (First, Middle, Las Annabell Ruth WYA	'					2	Date of De Month	Day	200 V	3. Time o	of Death
	/Medic Examin	54.	4a. Facility Name (If not institution, give Washington County				Town, or Lo		Death	/ <u>///</u>	4c. Coun	nty of Death ashin		
	Funeral Director		219-14-7563	7. Age (In yrs. I	last birthday) Yrs.	If Under Months		f Under 2 Hours	Min. N	Date of Bird (Month, Da (OV • 22	th ly, Year) 1923		place (State intry) ryland	
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Washing		y, Town or Lo								10d. Inside 0	City Limits
	with tha	Direc	10e. Street and Number 11814 Patrick Roa			10f. Zip	Code 1742				10g. Citizen o		intry?	
036	permit. Pagas 1 and 2 should ba filed within 72 hours after daath with tha Maryland Dapertmant of Hauth and Mantal Hygiana. Important: if Item 27 is marked other than "natural", or Itema 23e or 28e-f show apprintury or other traumatic event. It is Madical Examinating the notified at angle.	by Funeral	11. Marital Status 1 Never Married 2 Marned 3 Wildowed 4 Divorced	10. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:			ent of Hisp fy Cuban,	anic Origi Mexican, Specify:	in? (Specit Puerto Ric	fy Yes or No can, etc.)	- 14. R	ace - Ameri lack, White,		
Maryland 21215-0036	Jwithin 72 ho jiana. rthen "natur If e Medical	Completed	15. Decedent's EC (Specify only highest gra Elementary/Secondary (0-12) 12		(Give life.	dent's Usua kind of won DO NOT us omemal	k done dur. e retired)		of working		16b. Kind of	Business/Ir		
and ?	ld ba filed antal Hyg ked othe Ic event,	To Be C	17. Father's Name (First, Middle, Last) C. Russell Decker		,		18				, Maiden Sum 1th Sno	· ·		
Mary	d 2 shouth and M 7 is mar traumat	-	19a. Informant's Name/Relationship (Suzanne Suffecoo		1						er, City or Tow)
ore,	gas 1 and t of Haall if Item 2 or other	1	20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □	Removal from State	lace of Dispo emetery, crea	sition (Nam natory or ot	ne of ther place)		Dat	е	20c. Location			
Baltimore,	permit. Pa Dapertman Important: eny Injury once.	Ì	4 Donation 5 Other (Specifical Service Licer			. Name and	d Address	of Facility	MINN	ICH FU	Hager: NERAL :	HOME		land
Ē	Physician		23a. Part 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the death one cause on each line. Respirator	h. Do not ent	er the mode						rid. 2	Approxima Interval Be Onset and	etween
*	/Medical Examiner		resulting in death)	Due to (or as a consequence of the bound of	uence of):		nia							
8760,	death cartificata ba axecutad a attanding physician and ad for usa as tha burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Pulmonare Due to (or as a consequence)	y fibre	DS is								
P.O. Box 68	death cartif a attanding ad for usa as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	Ideath 3	Ectopic pre						Date of deliv	rery Day	Year
	n raquiras that baan signed b should ba dete	ò	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying ca	ause given	in Part I.			obacco use co Yes 2 No	_	the cause of	
Division of Vital Records,	as as ca	Completed	#*************************************							24a. Was auto perfo		b. Were auto prior to co death? 1 \sum Yes	opsy findings ompletion of	available cause of
Vita	Physician: r this cartific ral diractor,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ✓ No	Hospital:	JED/0					Check only				
ion of	To the Hospital or Attanding Physicien: Tha I within 24 hours after dash. To the Funaral Diractor: After this cartificata ha complataly filled in by tha funeral diractor, paga	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		8c. Injury a Work?	t	28		dence 6 C		ify)	
Divis	tal or Atts s after data al Diracto ad in by th	Certification:	3 Suicide 6 Could not b 4 Homicide determined		ome, farm, st	reet, factory	, office		28	f. Location (City or To	Street and Nur wn. State)	nber or Rur	al Route Nui	nber,
	e Hospital of 24 hours at the Funaral Distance is Funaral Distance is the second control of the second control	edical	29a. Certifier 12 Certifying Pt (Check only 2 Medical Examone)	eysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deat tion and/or in	h occurred a vestigation,	at the time, in my opin	, date and nion, death	1 place, an h occurred	d due to the l at the time,	cause(s) and date and place	manner as s e, and due t	stated. to the cause	(s)
)	To the within 2. To the Complate	Me	29b. Signature and title of certifier Mawai W	doly mp			D62		2		Jan 10		Day, Year)	
5	H-8		30. Name and address of person who WASNINGTON COU	completed cause of death (Item	n 23a) (Type,	Print) MAGER	STOWN	IVAI N,M	HUB	BU	2174	D		
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature A	Jan de	*	•						

			For State Registrar	State of Ma	arylan		artmen rtificate			ind M		giene Reg. No.	006	5 0	1313
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last Clara Bell Wills A. Facility Name (If not institution, give	street and number)	1		4b. City,	Town, or	Location o	f Death	2. Date of De Month	Day Q3	County of I	ear C(v)	Time of Death
	Funeral Director	86-1	Washington Count 5. Social Security Number 217–28–2127 6. Se			last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours		8. Date of Bir (Month, Da 05/05/	th ly, Year) 1927		Birthpface Country)	(State or Foreign
	Maryland s-f show fied at	tor	Usual Residence of Decedent 10a. State 10b. County MD Washin	gton		y, Town or Lo									Inside City Limits
	th with the 23s or 28s	Funeral Director	10e. Street and Number 610 N. Prospect	Street			10f. Zip 2.	Code 1740		-			zen of Wha JS	at Country?	ŀ
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Pyglene. Important: if Item 27 is marked other then "naturel", or Items 23a or 28a-f show strip injury or other traumatic event, Ire Moded Exertifier must be notified at ance.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Was Deced f Yes, spec 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)			American I White, etc. Blac	
21215-0036	d within 72 he giene. In then "netu	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i> College (1-4or 5	+)		dent's Usua kind of wor DO NOT us Lt Cai	rk done d se retired,	uring most		ng			ness/Indust	
Maryland	should be filed nd Mental Hygis marked other umatic event, III	To Be C	17. Father's Name (First, Middle, Last) Eddie (unk) Pina						Anna	a Be	(First, Middle,	iams			
	is 1 and 2 shot Mealth and Item 27 is m other traum		19a. Informant's Name/Relationship (T) Bridgett Wills / 20a. Method of Disposition		20h 8	L	V. Pro	ospe		reet	, Hager	stow	n, M		40
altimore,	t. Pages rtment of trant: if ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		C	emetery crer se Hill	natory or o	ther place etery	y 0.	1/12	/2006	Hag	ersto	own, l	MD
Bal	permit. Departiments Imports eny inji		21. Signature of Funaral Service Licens 22. Part Fine the disease or comp	Senif	The death	30	Name and No.	Pote	omac :	Stre	et, Hag	erst		MD 2	ral Home 1740 proximate
	Physician /Medical		shock, or heart failure. List only o fmmediate Cause (Final disease or condition resulting in death)	a	119	mant	?	1	~ al	E	ffus	5, 6	`	Inte	erval Between nset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	VO V	nany	P	Pri	iry	7	152R	51			
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	Ical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseq	uence of):									
P.O. Box 68	death certif e attending ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. ff yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐Feta	Ideath 3□	Ectopic pr Other (sp					2	3d. Date o	f delivery Day	y Year
	law requires that the as been signed by th 2 should be detache	þ	Part If, Other significant conditions co	ntributing to death b		ulting in the u	nderlying c	ause give	n in Part I.			obacco u Yes 2[te to the ca	ause of death?
Division of Vital Records,	The ete h page	e Completed	25. Was case referred to medical								1□ Yes	osy ormed? 2 No	prio	r to comple	findings available stion of cause of
f Vii	Physician: rthis certificatal director.	To Be	examiner?	Hospital:	nt 2	ER/Outpatier	at 3□ DC	A Othe			(Check only only only one 5 ☐ Resident		Other ((Specify)	
ion o	Attending Pr r death. ector: After th by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry Year)	28b. Time of Injury	M 2	8c. Injury Work	at ? ∕es 2 □ N		28d. Describe I	how injury	occurred		
Divis	e e in in in in in in in in in in in in in	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injuding, et			eet, factory	r, office		2	28f. Location (: City or Tox		d Number o	or Rural Ro	ute Number,
	he Hospitel n 24 hours a he Funeral I pletely filled	ledical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best nar: On the basis of and manner sta	examina	wledge, deatl tion and/or in	n occurred vestigation,	at the tim , in my op	e, date and inion, deat	d place, a h occurre	and due to the ad at the time,	cause(s) date and	and manne place, and	er as stated due to the	d. cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	much	^				603			01	signed (A	onth, Day,	, Year)
SF	1-4		30. Name and address of person who c		eath (ften	п 23а) (Туре,	Print)	112	6 0	pal	et ex	a se a	m	D	
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	iture	os M			- 11	J	,			

			r lease 1	State of Marylan		ot of Health and	-	_	•
			For State Registrar	Otate of Marylan		e of Death		Reg. No.2 0 0 6	01316
			Decedent's Name (First, Middle, Last)				2. Date of Dea	ath	3. Time of Death
	Physicia /Medic		Donis	Mallich			Month	Day Yea	1 1 7 7 14
di.	Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City,	Town, or Location of Deat	h	4c. County of De	ath
			PONC	7. 4		TON, MO	10.000	Prince	
П	Funeral Director		5. Social Security Number 6. Sex 1	M 2 X F 7. Age (In yrs. 76	Yrs. Months			7 Year) 1929 Wa	irthplace <i>(State or Foreign</i> Country) Shington DC
			Usual Residence of Decedent	70			Dec. 10	J, 1329 Wa	Sirring con DC
	show	_	10a. State 10b. County		y, Town or Location				10d. Inside City Limits
	Sa-f s	ecto	Maryland Prince Go	eorge's	Accokeek				1 □ Yes 2 ₩ No
	within 72 hours after death with the Maryland ene. then "netures", or flems 23a or 28a-f show the Madical Examiner is ust be rediffed at	Funeral Director	15000 April Street		10f. Zij	20607		10g. Citizen of What o	Country?
	death ms 23	era		2. Was Decedent Ever in U	.S. 13. Was Dece	dent of Hispanic Origin? (S cify Cuban, Mexican, Puer	Specify Yes or No-		nerican Indian,
9	or Ite	Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		cify Cuban, Mexican, Puer 2X No Specify:	to Rican, etc.)		white White
003	ursi',	Completed by	3 Midowed 4 Divorced	Year or Dates:				Specify:	
15-("nati	lete	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decedent's Usu (Give kind of wo	al Occupation ork done during most of wo use retired)	rking	16b. Kind of Busines	ss/Industry
12	l withi	omp	Elementary/Secondary (0-12)	College (1-4or 5+)	Cook	,		Schools	
פ	l be filed within that Hygiene.	BeC	17. Father's Name (First, Middle, Last)					Maiden Sumame)	
lar	should be and Menta s marked umatic s	ToE	Harry J. Adkins			Ruth A	dkins		
Maryland 21215-0036	2 shc and is m		19a. Informant's Name/Relationship (Typ			s /Street and Number or Ri			
	1 and 2 Health tem 27		Dennis Burkett, Sr 20a. Method of Disposition		2 5930 K1 Place of Disposition (Na cemetery, crematory or	ver Road, Bry	yans Road	20c. Location - City	
nor	Pages nent of int: If it iry or o		1 ☑ ABurial 2 ☐ Cremation 3 ☐ Ro '4 ☐ Donation 5 ☐ Other (Specify)	ernoval from State		ial Gdns 1-7	-06	Waldorf,	
Baltimore,	교육관금 .		21. Signature of Funeral Service License	MODOFO		nd Address of Facility		Old Washin	
ä	Depa Impo sny i		Mark MISHOR	ann	Huntt	Funeral Home		rf, MD 206	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the deat le cause on each line.	h. Do not enter the mo	de of dying, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	OVARIA	N Cance	W			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):				
	4 A	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	ruence of):				
	cuted id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
Ó,	be executed icien and burial-transit		resulting in death) Last	Due to (or as a consec	uence of):				
8760,	9 × 0	dicai	d	l					
89 X	death certifica e attending ph od for use as th	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregna	ancv			23d. Date of o	lalivas
Вох	death atten	ciar	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3 Ectopic p			Month	Day Year
P.O.	that the death sed by the atter detached for t	hys	9 Unknown	9□ Unknown					<u> </u>
	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions con	tributing to death but not res	sulting in the underlying	cause given in Part I.			to the cause of death?
ord	requir	ted					1 U Y	res 2 No 3□	Probably 4 ☐Unknown
Vital Records,	e - 5	Completed					24a. Was autop		autopsy findings available o completion of cause of
al	ician: The l certificale ha	e Co	OF Was assessed to medical				1 Yes	2 No 1 Y	es 2 No
₹		o B	25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 Inpatient 2	ER/Outpatient 3 Di	Other	ath (Check only o	ine) dence 6 ⊡Other (Si	necify)
J Of	ng Phys ter this neral di	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)		28c. Injury at Work?		now injury occurred	,
Siol	Attending in death.	catic	2 Accident investigation		М	1 Tes 2 No			
Division	or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		y, office	28f. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,
_	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	al Ce	29a. Certifier Cartifying Phys	sician: To the best of my kno	owledge, death occurred	at the time, date and place	e, and due to the	cause(s) and manner	as stated.
	Ne Ho	edical	(Check only 2 Madical Examinations)	ner: On the basis of examina	ation and/or investigation	n, in my opinion, death occ	urred at the time,	date and place, and d	ue to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of pertifier		29	c. License number		29d. Date signed (Mo	onth, Day, Year)
,	`		Wellin O an	nen Mrs		D3 (50%		JOHUM ?	2, 2006
1	185		30. Name and address of person who co	ompleted cause of death (Itel	m 23a) (Type, Print)	D3 (206) Rowd, Font	L. J. Action	ch. same	ula 1
(Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature		MASHIN	Ar wess	117
6	Regist		JAN 0 5 20	006 Alexan	B. Good	1			

			For State Registrar	State of Maryl			of Health		ental Hy	giene Reg. No.	16	0 3 5
¥.		G-1	Decedent's Name (First, Middle, Las	t)					2. Date of De		V	3. Time of Death
	Physici /Medio	_	Wil:	iam Edward V	Winters,	Sr.			JANUAR		2006	8:30 a ^M
T.	Examin		4a. Facility Name (If not institution, give	·		,	Fown, or Locatio			4c. County		
	* 1	-	St. Mary's Hospit 5. Social Security Number 6. Sec		yrs. last birthday)		nardtown		8. Date of Bir	St. 1		
	Funeral Director		577-12-7213	ŽM 2□F / 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	87 Yrs.	Months		s Min.	(Month, Da	ay, Year)	Distri	place (State or Foreign ntry) Lct of Columbia
200	√ak ^a		Usual Residence of Decedent						NOVEMBEL	20,1710	DISCI	CC OI GOIGIBLE
	urylan uhow	_	10a. State 10b. County		c. City, Town or Lo	ocation						10d. Inside City Limits
	Ba-f	Director	Maryland St. Mary	's]	Leonardt							1 ☐ Yes 2 No
	with the or 2	吉	10e. Street and Number			10f. Zip				10g. Citizen of	What Cou	ntry?
	leath	Funeral	43853 Dots Lane 11. Marital Status	12. Was Decedent Ever	in U.S. 13.		550 ent of Hispanic (Origin? (Spe	cify Yes or No	USA 14. Rad	e - Ameri	can Indian,
က္	or iten		1 ☐ Never Married 2X Married	Armed Forces? 1 X Yes 2 □ No			ent of Hispanic (ify Cuban, Mexic		Rican, etc.)		ck, White	
03	rei', c	1 by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	No Speci	ry:		Specil	whi	te
5-0	72 h "natu	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	kind of wor	Decupation k done during m	ost of working	ng	16b. Kind of B		
12	within ane. than	E G	Elementary/Secondary (0-12)	College (1-4or 5+)	Owne:	DO NOT us ~	в гептва)					
d 2	be filed within 72 hours after death with the Marylan ital Hygiene. Indoorber than "natural", or itame 23a or 28a-f ahow event, the Madical Examiner must be notified at	e Cc	17. Father's Name (First, Middle, Last)	-	Owne	<u> </u>	18. Mo	ther's Name		<u>Heating &</u> , Maiden Sumai		onditioning
<u>a</u> n	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked other than "natural", or iteme 23s or 28s-f ahow umatic event, the Madical Examiner must be notilled at	To B	Ernest Winters				Agne	es Vir	ginia :	Brown		
ary	s 1 and 2 should t Heelth and Mer itam 27 is marks other traumatic		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address				er, City or Town	, State, Zi	Code)
Σ	and 2 sellth in 27 i	- 11	Margaret Maske Winters				ane, Leona					
Baltimore, Maryland 21215-0036	des 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	Ob. Place of Dispo cemetery, crei	osition (Nan matory or o	ne of ther place)		_{ate} uary	20c. Location	- City or T	own, State
Ë	: Pag tment tent:		4 ☐ Donation 5 ☐ Other (Specify) Н	loly Face C				2006	Great Mi	11s, M	aryland
Ba	permit. Pages 1 and 3 Depertment of Heelth important: If item 27 any injury or other tr. 0069.		21. Signature of Funeral Service Lices	500//	Ma	ttingle	d Address of Face ey-Gardine	er Fune:	ral Home	, P.A.		
			23a. Part1. Enter the disease, or com	plications that caused the						and 20650		Approximate
	Division	10	shock, or heart failure. List only Immediate Cause (Final	one cause on each line.					_			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a FICO	h ors	718	ance y	0/3	,025	2	-	DAYS
- 8	Examiner			b. Due to (or as a cor	ive	RISK	rt Pla	usul	6/4	1510h	. /	2176
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence of):		- 4	04	e 10	malign	ancy.	
	ecute and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Ou or or	05+100	N	9414	1911	uor		183	12475
8760,	cate be executed bhysicien and the burial-transit	ai E			995+	ى رو	mars				1161	17975
	ficate physis the	edicai		d ~ x / O = \	J	, -						
S SR.	eath certific attending p	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		n=				23d. Da	te of deliv	ery
SS.	death	icia	in the past 12 months? 1 Yes 2 No	1 Live birth 2 L		□Ectopic pro □ Other (sp				M	onth	Day Year
P.O.	that the de ed by the a detached t	hys	9 🗆 Unknown	9□ Unknown								
	8 5 0	by	Part II. Other significant conditions of	ontributing to death but no	t resulting in the u	inderlying ca	ause given in Pa	rt I.				he cause of death?
2 o	w require been sig should b	eted			4				-	Yes 2 No		bably 4 □Unknown
EDWARD tal Fleco	has b	Completed							24a. Was	an 24b. psy ormed?	Were autoprior to co death?	opsy findings available impletion of cause of
EDW al F									1 Yes	2.2 No	1 Yes	2 No
Z Z	sicier	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ☐ ER/Outpatie	nt 3 DO	Othor		Check only		(0	4.1
WILLIAM sion of V	Phys er this eral di	n; To	27. Manner of Death	28a. Date of Injury (Month, Day Yea			Bc. Injury at Work?			how injury occu		(y)
i i	Attending P death. ctor: After I y the funera	atio	1 ØNatural 5 ☐ Pending 2 ☐ Accident investigation	1	ar) Injury	М	work? 1 ☐ Yes 2	□No				
WILLIAM EDWARD WIN Division of Vital Fecords,	or Atteated	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S)	At home, farm, st	reet, factory	, office	1	28f. Location (Street and Num wn, State)	ber or Rur	al Route Number,
	spital or A ours after neral Directilled in by				<u> </u>							
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Icai	(Check only 2 Medical Exam	y sician : To the best of my niner: On the basis of exa								
	To the Hos within 24 ha To the Fun completely	Medical	one) 29b. Signature and title of certifier	and manner stated.		290	. License numbe	er	1	29d. Date signe	ed (Month	Day Year)
	F3F8			iv, L		7	001-1	719		1-10	01	/
	5 ~		30. Name and address of person who		(Item 23a) (Type	Print)	10001	'		1-10	<u> </u>	>
•	M.		DHANANJAY V BHA		ASSOC HO	ŕ	OOD MD	20636				
	Sta		31. Date filed (Month, Day, Year) JAN 1 1 2	32. egistrar's S		6 mg						
157.266	Regist	ar	V/11 4 1 2	THE STATE OF THE PARTY OF THE P	15 1	THE REAL PROPERTY.						

			For Amend Items 2	State of M	aryland 1, 25, 27,	lepai 28a Cert	tment of H	ealth and G852,02 Death	Mental Hyd 17/06dHi	iene 2005	01316
ą	Dhysisi	No.	1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	Day Year	3. Time of Death
	Physicia /Medic	- 31	Eleanor Lorett						January		10:40PM
1	Examin	er	4a. Facility Name (If not institution, give s St. Mary's Nursin				4b. City, Town, or Leonardt		h	St. Mar	
	Francis		5. Social Security Number 6. Sex		je (In yrs. last bir	thday)	If Under 1 Year	If Under 24 Hrs			thplace (State or Foreign ountry)
н	Funeral Director	10	220-16-9041	M 20 X F	93	Yrs.	Months Days	Hours Min.			ryland
7	pu >		Usual Residence of Decedent 10a, State 10b, County		10c. City, Tow	n or Loc	ation				10d. Inside City Limits
	faryla ed al	or	Maryland St. Mary	.t _s	Charle						1 ☐ Yes 2 🛣 No
	the N 28e-f	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What C	ountry?
	3a or	i Di	29755 Leonardtown	Road			20622	2		USA	
	death	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (S	Specify Yes or No-	14. Race - Am Black, Wh	
92	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23a or 28e-f ehow ha Madigal Examerer must be notified at	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 🔀 If Yes, Give		1	Tes 2⊠ No	Specify:	10 / 1104/11, 010.7		White
00	hours tural',	ed by	3 X Widowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:	162	Decede	int's Usual Decupa	ition		16b. Kind of Business	Modustry
5	in 72 n "naf	piete	(Specify only highest grade	completed)		(Give k	ind of work done of NOT use retired	luring most of wo	rking	Too. King of busines.	a moustry
21215-0036	d with	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Own	ner			Produce M	arket
	be filed tal Hygid d other event, I	Be	17. Father's Name (First, Middle, Last)						me (First, Middle,		
Уa	should the market umartic	T _o	John Edward Gass	0:0	101	h # 1/1			ee Hayde:		7-0-1-1
Maryland	d 2 sho th and 7 le mu traum		19a. Informant's Name/Relationship (Ty) Phillip Alvin Wood			_				r, City or Town, State, MD 20622	Zip Code)
_	Heal Heal tem 2	1	20a. Method of Disposition	, 5011	20b. Place of	f Dispos	ition (Name of atory or other place		Date	20c. Location - City o	r Town, State
OE I	Pages nent of i		1X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1		s Cemeter	Ja	n. 2006	Bryantown, M	laryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: It Item 27 is marked other than "natural; or Items 23a or 28e-1 show important: It Item 27 is marked other than "natural; or Items 23a or 28e-1 show any injury or other traumatic event, the Mudical Examiner must be notified at once.		21. Signaruje of Funeral Service License	Herdener	.0				neral Home own, MD 200		
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that cause	d the death. Do						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ATTERIO		20110	CATE	no VA	- hirasse	Onset and Death	
	/Medical		resulting in death)	Due to (or as	a consequence	of):			200		
	Examiner		Sequentially list conditions,	11 1 P	114	£16	ne -		N APPROVED BY ME	MILER	17.793
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	OI):		\bigcap	AAN KWE	DICAL EXAMINE	
,	execunand and all-train	xar	that initiated events resulting in death) Last	Due to (or as	s a consequence	of):		1	N APPROVED BY		
8760,	death certificate be executed e attending physicien and id for use as the burial-transit	dical	L.	l				CERTIFICAT			
9	ntifica ng ph s as th	Medi	IF FEMALE:								
Box	ath ce ttendi or use	an/	23b. Was decedent pregnant in the past 12 moeths?		2 Fetal death		Ectopic pregnancy			23d. Date of de Month	elivery Day Year
_	that the death certificed by the attending properties as	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregnant a 9☐ Unknown	it time of death	5	Dther (specify)				
P.O.	requires that the een signed by th hould be detache	y Ph	Part II. Other significant conditions con		but not resulting i	n the un	derlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
Vital Records,	quires n sign uld be	ed by	M211ETWIG	45 1)	CM EX	TIA	t		1 🗆 Y	es 2∏No 3∏F	Probably 4 □Unknown
000	> 10	Completed	Hip fracture						24a. Was autop		autopsy findings available completion of cause of
R	The ate has page	Com							perfor	med? death?	
/ita	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	La contract			1 04		ath Check only o		
of	Phys this al dii	7 C	1 X Yes € 10 Yes 27, Manner of Death	lospital: 1 Inpati 28a. Date of Inj		utpatient Time of		4 Wursing		ence 6 Other (Sp	ecify)
Division of	ling After une	Certification:	TENATURAI 5 Pending 2 Accident investigation	01/07/2		30° a	28c. Injun World	Yes X No	Subjec		
/isi	Attending r death. ector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be						28f. Location (S	Street and Number or F	Rural Route Number,
Ö	s after s afte	Certi	4 Homicide	nursi	njury - At home, fa tc. (Specify) ng home				St. Mar	v's Nursin	g Ctr. MD
	To the Hospitel or Attend within 24 hours after death To the Funeral Director; completely filled in by the i	edical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the besi ner: On the basis and manner s	of examination ar	e, death nd/or inv	occurred at the tin estigation, in my o	ne, date and plac pinion, death occ	e, and one to the ourred at the time, o	ause(s) and manner a date and place, and du	Leonarotown as stateu. ue to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and little of certifier		MI	>	29c. Licens			29d. Date signed (Mor	
		8	30 Name and address of parson upon	moleted cause of	death (Item 23a)	(Type 5	Print)			, , = 0	
			30. Name and address of person who co	S. 612		AH	ASSOCI	ATES	160	1-12-0 YNDOD	MD
State 31. Date filed (Month, Nay, 1ea) 2006 Registrar							4				

			1 - For Stata Registrar	State of Ma		partment <i>ertificate</i>		and Mental	Hygiene Reg. No	. 0 0 0	01317
	Physici	an	Decedent's Name (First, Middle, L.)					2. Date Monti JAN	of Death h Da	y Year	3. Time of Death
	/Medio	cal	MAMIE POPE WA							2006	11:30A M
7	Examir	ier	4a. Facility Name (If not institution, g SHADY GROVE AD	ve street and number! VENTECT	URSING		own, or Location	of Death		. County of Deat	
					HOME		VILLE Year If Unde	er 24 Hrs. 8. Date		MONTGOM	
	Funeral Director			1□M 2 3 F	95 Yrs	Months	Days Hours	Min. MAR	of Birth h. Day, Year)	910	nplace (State or Foreign untry) NC
	Maryland f show	ō	10a. State 10b. County	GOMERY	10c. City, Town o	CHASE			·		10d. Inside City Limits 1 Yes 2 No
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygjene. It has a starked other than "naturel", or Items 23a or 28e-f show other traumatic event, If a Medical Examination at the neithfield at	Funeral Director	10e. Street and Number 7200 CONNECTI	CUT AVE.		10f. Zip C 20	815		-	izen of What Co	untry?
	death	nera	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	3. Was Decede	nt of Hispanic O	origin? (Specify Yes an, Puerto Rican, etc	or No-	14. Race - Ame	
9	or Ite	F.	1 Never Married 2 Married	1 Tes 270	lo	1 Yes 2	2		;.)	Black, White	
003	urel',	d by	3 Widowed 4 □ Divorced	Year or Dates:				··		Specify: WH	ITIE
215-0036	"natu	Completed	15. Decedent's (Specify only highest g	Education rade completed)	1 (6	ecedent's Usual live kind of work	done durina ma	st of working	16b. K	ind of Business/	ndustry
12	within ene. than "	E G	Elementary/Secondary (0-12)	College (1-4or 5	+)	LE CLE			GOV	/'T. PR	INTING
d 21	filed withi Hygiene. other than ent, Ire M		12 17. Father's Name (First, Middle, Las				· · · · · · · · · · · · · · · · · · ·	ner's Name (First, M			
an	d be ental ked o	To Be	EUGENE G. POP				i	A DEAL			
Maryland	2 should be and Mental Is marked o sumatic eve	-	19a. Informant's Name/Relationship		19b. M	ailing Address (Street and Numi	ber or Rural Route N	lumber, City o	or Town, State, Z	^(ip Code) 20815
	1 and 2 Health a tem 27 is		ADA QUATTROCCH	I/DAUGHTE	R 780	0 CONN	ECTICU	T AVE.,	CHEVY	CHASE	, MD
altimore,	permit. Pages 1 a Department of Hec Important: If item any injury or othe once.		20a. Method of Disposition	Eta v a	20b. Place of Di	sposition (Name crematory or oth	of er place)	Date	20c. Lo	ocation - City or	Fown, State
Ē	Page nent o ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Cremation 3 ☐ Other (Special Control of Con					1/7/06	DUF	RHAM, N	C
alt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lic	ensee	i	22. Name and	Address of Faci	RAL HOME	י		
8	2077 20		100 Dy			P.O.	BOX 86	BARNES	ZATTTE	E, MD 2	0838
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	mplications that caused y one cause on each lin	θ.	enter the mode	of dying, such a		dvan	cod	Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of):			-	K. V.CY	Cell	
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	ed sit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of:						
	certificate be executed ding physicien and ise as the burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a	a consequence of):						
8760,	sicier buris	aiE									
687	ificate g phy: as the	Physician/Medicai		d							
Вох	eath certific attending pl	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		- OF				23d. Date of deli	very
Ď.	death	icia	in the past 12 months?	1□Live birth 4□Pregnant at		3 □Ectopic prec 5 □ Other (spec				Month	Day Year
P.0	that the de ned by the a detached f	hys	9 Unknown	9∐ Unknown							
	law requires that the as been signed by th 2 should be detache	5	Part II. Other significant conditions	contributing to death bu	it not resulting in th	e underlying cau	ise given in Part	I, 23e.		_	the cause of death?
Records,	requi	Completed							1 ⊔ Yes 2	∠ NO 3∐ Pro	obably 4 □Unknown
ec	alaw nasb e2st	npie							Was an autopsy	24b. Were au prior to d	topsy findings available ompletion of cause of
H	: The cate ha	Con						101	performed? (es 22 No		2 □ No
Vital	Physician: The law this certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			0.1	e of Death (Check of			
of	Phy this ald	2	1 Yes 2 No	1 Unpatie	nt 2 ER/Outpa			lursing Home 5			ify)
'n	Jing After fune	ion	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	y 28b. Tim Yea <i>r)</i> Inju	e of 280	c. Injury at Work? 1 ☐ Yes 2 ☐		ribe how injur	y occurred	
isi	Attending r death. ector: After	icat	2 Accident investigate 3 Suicide 6 Could not	be Diese of Isia	ıry - At home, farm				ion (Street an	d Number or Qu	ral Route Number,
Division	after Direct	Certification:	4 Homicide determine	building, etc	. (Specify)	, street, lactory, t	omea	City	or Town, State	e)	rai noute Number,
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of the basis of and manner sta	examination and/o	eath occurred at r investigation, ir	the time, date a n my opinion, de	and place, and due to eath occurred at the	the cause(s)	and manner as I place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and the of certifier			29c. I	License number		29d. Da	te signed (Month	, Day, Year)
	- 5 - 0		1///	2-2-7-	•		240	77	-	1-06	-06
	5		30. Name and address of person wh	completed cause of de	eath (Item 23a) (Tv	pe, Print)	900	1.0		3	
			30. Name and address of person who	avar MD)	160	10000	1302, SUM	c # 404	Z	
· .	Sta		31. Date filed (Month, Day, Year)		r's Signature	freet.	77371	7, 110	30110		
	_ Registi	ar	JAN 0	A COMO	The second	MANAGE					

CPM 06-00335 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Unpend item# 1.23a.PII.27, penME. 0854, 446/06.TT State of Maryland / Department of Health and Mental Hygiene George Werking, Jr. For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month George Werking, Jr. Year **Physician** 13 George January 2006 18:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year | If Under 24 Hrs. Harbor Hospital Center 8. Date of Birth (Month, Day, Year) March 26, I 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days **₩**M 2□ F Yrs. 1967 Washington D.C. Director 38 212-06-0901 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "naturel, or iteme 23s or 28s-1 show vent, the Madical Examiner must be notified at 1⊈ Yes 2 □ No Directo Anne Arundel Annapolis Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21403 United States 10 Horn Point Court death by Funera 12. Was Decedent Ever in U.S.
Armed Forces?
1 ⊠Yes 2 □ No 1989—
If Yes, Give
Year or Dates: 1991 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel; or item any injury or other traumatic event, the Madical Examina 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Self Employed Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Samuel Werking, Jr. Glenna Faye Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George S. Werking / Father 10 Horn Point Court Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ☐ Burial 2
☐ Cremation 3 ☐ Removal from State Baltimore Crematory 1/16/ 2006 Baltimore, Maryland 4 □Donation 15 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Cloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cardiac arrhythmia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed physician and s the burial-transit Exam Due to (or as a consequence of) P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? for u 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ned by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ sign 1 be Hypoglycemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Completed been si should 24b. Were autopsy findings available prior to completion of cause of death?

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete has l lirector, page 2 s autopsy performed? Yes Yes 2 ☐ No director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 XYes 2 No : After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation death 1 Yes 2 No Director: / 2 Accident 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter of To the Funeral Direct completely filled in by determined 4 T Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. January 14, 2006 30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print) TIPL MID. sha M. 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 3 Registrar's Signature State

Registrar

JAN 1 7 2006

			1 For State	State of Ma	ırylan		artment of H		nd Mer	ntal Hyg	giene	NG	01319
			Registrar 1. Decedent's Name (First, Middle, Las	21)		Cei	tilicate of	Death	2	Date of Dea	eg. Nb."		3. Time of Death
	Physici		William B	10	115	con	JA			Month	Day	Year	0825 M
200	/Medio Examir		4a, Facility Name (If not institution, give	street and number)	1	1	4b_City, Town, o	r Location of	f Death	an	4c. Count		. 0033
-6	LXamii	gil.	Coastal Hosp	ice atth	ساي	ake	Sali	Sba	14		6	Vic	omico
	Funeral	T. rate	5. Social Security Number 6. S	ex 7. Age	(In yrs.	last birthday)	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day	Year)	9. Birthp	place (State or Foreign
久	Director		215-38-2375 ¹ Usual Residence of Decedent	AM ZUF	66	Yrs.			8	/9/19:	39		land
	land w		10a. State 10b. County		10c. City	y, Town or Lo	cation					1	0d. Inside City Limits
	Mary	tor	Maryland Wicomic	:0		Salish	oury						1≹Yes 2□No
	or 28s	lrec	10e. Street and Number				10f. Zip Code			1	l0g. Citizen of	What Cour	ntry?
	72 hours after death with the Maryland neturel', or Iteme 23a or 28a-f ehow disal Examinat must be roillied at	Funeral Director	420 Pinehurst Av	e.			218	01			USA		
	de de de de de de de de de de de de de d	nue	11. Marital Status	12. Was Decedent E Armed Forces?			Was Decedent of H f Yes, specify Cuba	lispanic Orig an, Mexican,	in? (Specify Puerto Rica	Yes or No- an, etc.)		ce - Americ	
36	rs afte		1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠ Yes 2 □ N If Yes, Give Z Year or Dates:	°irFc	rce	I□Yes 2⊠No	Specify:			Specia	_{fy:} wh	nite
21215-0036	Phou	Completed by	15. Decedent's Ed	fucation			ient's Usual Occup	ation		1	16b. Kind of E	lusiness/Inc	dustry
212	within 72 ene. then "no	plet	(Specify only highest gra	de completed) College (1-4or 5-	+)	(Give life. l	kind of work done of OO NOT use retired	during most 1)	of working				,
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pu	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other then "neturel", or iteme 23a or 28a-1 show or other traumatic event, the Madical Examinat must be rotified at	Be	17. Father's Name (First, Middle, Last) William Bruce Wi						•		Maiden Sumai	me)	
Maryland	should ind Men marke umatic	ဥ				1			ise B				
Mar	12 sh h and 7 le m traum		19a. Informant's Name/Relationship (1997) Peggy P. Wilson/	*			g Address (Street) Pinehur						
	1 and Healt em 2		20a. Method of Disposition	WIIC	20b. P	lace of Dispo	sition (Name of	1	Date		20c. Location		
JOI.	ages ant of t: If it y or o		1 ☐ Maurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi		Be	emetery, crem Elle Ha	natory or other plac I VEN	(e)	L/7/06				
Baltimore,	permit. Pages 1 and: Depertment of Health Important: If Item 27 eny injury or other tr anges.		21. Signature of Euneral Service Licen		Ce	metery	Name and Addres	ss of Facility	200	-			en, VA
Ä	Depermine timbo	ļ.,	21. Signature of Funeral Service Licensia e Work Read Corp. 22. Name and Address of Facility Holloway Funeral Home Professional A 501 Snow Hill Rd., Salisbury, MD 2180									ssociation	
5			23a. Part1. Enter the disease, or com shock, or heart failure. List only		the death	n. Do not ent						D ZIC	Approximate Interval Between
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1	/Medical		resulting in death)	Due to (or as a				RCI	1				
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):									
	xecut and	хап	that initiated events resulting in death) Last	c. Due to (or as a	a consequ	uence of):							
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dicai E		d									
9	ifficate g phy as the	edic											
Вох	eath certific attending p	m/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Ectopic pregnancy				23d. Da	ate of delive	ery
	o deat	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at			Other (specify)				Mo	onth	Day Year
P.0	that the de led by the a detached t	Phy	9 Unknown										
	res that signed to be det		Part II. Other significant conditions c	ontributing to death bu	it not rest	ulting in the ur	iderlying cause givi	en in Part I.		23e. Did tot	.	tribute to th 3 □ Prob	ne cause of death? ably 4 □Unknown
Records,	w require been sign	Completed by									-		
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		e Co	25. Was case referred to medical						15 1 10		1-0		X No
Ş	Physician: this certifical director,	To Be	examiner?	Hospital: 1 ☐ Inpatier	nt 2 🗆	ER/Outpatien	t 3 DOA Oth	05		heck only on 5 □ Reside		ner (Specify	HOLEIL 2
Jo L	g Phy er thi		27. Manner of Death	28a. Date of Injur (Month, Day	v	28b. Time of	28c. Injury				ow injury occur		111311012
Division	ath. or: Aft	Certification:	1 Accident 5 ☐ Pending 2 ☐ Accident investigation		(Gar)	Injury		Yes 2 □ N	lo				
Ξį	irecto	rtific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At ho	ome, farm, str	et, factory, office		28f.	Location (St City or Town		ber or Rura	l Route Number,
0	oitel ours af												
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exan	ysician: To the best on niner: On the basis of and manner state	examinat	wledge, death tion and/or inv	occurred at the ting restigation, in my o	ne, date and pinion, death	place, and noccurred a	due to the ca it the time, di	ause(s) and ma ate and place,	anner as st and due to	ated. the cause(s)
	o the ithin (o the omple	Med	29b. Signature and title of certifier	and manner sta			29c. Licensi	e number		2	9d. Date signe	ed (Month, i	Day, Year)
	× 2 × 3		roll.			-1	Dep	C76	110		01/03,		,
`	1,00		30. Name and address of person who	completed cause of de	eath (Item	23a) (Type.	Print)	230			1		
	- CO				620	66 A	PROWW	000	CT.	SHI	issur	24 4	1021801
	Sta		31. Date filed (Month, Day, Year)	32. Registra		ture						-	
i his	Regist	ar	JAN 0 6	CUUD COM	42.1	H. A	and i						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

		-	For State Registrar	State of M	-	epartment of H Certificate of I			Reg. No. 006	01320	
	Physicia		Decedent's Name (First, Mid					2. Date of Dea Month 1/1/2		3. Time of Death	
>	/Medic	al -	Perrie Wilson 4a. Facility Name (If not institut.			4b. City. Town, or	Location of Death	1/1/2	4c. County of Dea	3:30 A M	
	Examin	er	4416 Island V		Worcester						
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 3/19/1		rthplace (State or Foreign ountry)	
	Director	-	530-16-6176 Usual Residence of Decedent) ZZ (VI Z Z I	86 Y	rs.		3/19/1	919	MD	
	yland how		10a. State 10b. Coun	ty	10c. City, Town	or Location				10d. Inside City Limits	
	Ba-f sl	Director		cester	Snow					1 Tes 2 XNo	
	with the		10e. Street and Number 4416 Island	Viou Dd		10f. Zip Code	1863		10g. Citizen of What C USA	ountry?	
	death ms 23	Funeral	11. Marital Status	12. Was Decedent		13. Was Decedent of H If Yes, specify Cuba		ecify Yes or No-			
Maryland 21215-0036	72 hours after death with the Maryland Instural; or Itams 23a or 28a-f show Vical Examination must be notified at	by	1 Never Married 2 M 3 Widowed 4 Divorc	Armed Forces? arried 1 ∑ Yes 2 □ If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:	Hican, etc.)		White	
2-0	72 hours "natural", dical Ex-	Completed	15. Deced (Specify only high	ent's Education hest grade completed)	16a. I	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	ation during most of work	ding ding	16b. Kind of Busines	6b. Kind of Business/Industry	
121	filed within Hygiene. Ithar than "	duic	Elementary/Secondary (0-12) College (1-4or 5+	5+)	Poultry Gr			Poultry I	ndustrv	
d 2	illed withi Hygiene. othar than	Be Co	17. Father's Name (First, Middle	e, Last)				e (First, Middle,	Maiden Sumame)		
/lar	should be filed ind Mental Hygi markad othar umatic evant, I	To B	Richard L. V	laters				h Wilso			
Mar	12 sho h and 7 is mu traum		19a. Informant's Name/Relation Martha Puse			Mailing Address (Street 5349 Shell				Zip Code)	
	s 1 and 2 should be filed within 72 ho if Health and Mental Hygiene. item 27 is marked or that than "natur othar traumatic event, the Mudical		20a. Method of Disposition		20b. Place of	Disposition (Name of crematory or other place		Date	20c. Location - City of	r Town, State	
E O	Page ent o nt: If ry or		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other	n 3 □Removal from State (Specify)	'	enlonen Cre	m. 1/3/	2005	Frankford	. De	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funes Service Licensee 22. Name and Address of Facility The Burbage Funeral Ho 108 William St., Berlin, MD 21811								
			23a. Part1. Enter the disease, shock, or heart failure. L	or complications that cause ist only one cause in each	d the death. Do no	ot enter the mode of dyin	ng, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Death,	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Ade	no car	zinona_	unkr	my k	rimary	2 months	
	Examiner				a consequence o	f):		S	source !		
	, .	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence o	f):					
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence o	4)·					
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	alE		d	,	.,,					
	tificate ng phys as the	ledical		d.							
Вох	attending for use	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregnancy	y		23d. Date of d Month	elivery Day Year	
O. E	he dea the at	ysicl	1 Yes 2 No	4□Pregnant a 9□Unknown	at time of death	5 Other (specify)				,	
σ.	res that the de igned by the a be detached t	by Ph	Part II. Other significant cond	litions contributing to death	but not resulting in	the underlying cause give	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?	
rds	v requires been sig should be	ted b	post obst	notive pu	lumoni	a		1 🗆 1	Yes 2□No 3□	Probably 4 ☐Unknown	
Records,	law requas been a 2 shoul	Completed	avenia	of neop	astic (chsease		24a. Was autop	an 24b. Were prior to death	autopsy findings available completion of cause of	
			,	U	<u> </u>			1 ☐ Yes	2 ₩ No 1 1 Y	es 2 No	
of Vital	Physician: The lav r this certificate has ral director, page 2	o Be	25. Was case referred to med examiner?	Hospital:	ient 2 ☐ ER/Out	tpatient 3 DOA Oth	26. Place of Dea ner: 4 Nursing H		one) dence 6 ∐Other(Sp	pecify)	
n of	ng Phy ter thi	n: T	27. Manner of Deat	28a. Date of Inj	ury 28b. T	ime of 28c. Injury	ry at		how injury occurred		
sio	Attending r death. actor: After by the fune	catle	2 Accident inve	estigation		M 1	Yes 2 □ No	286 Location /6	Street and Number or	Pural Poute Number	
Division	after d Diract Jin by	Certification:		amined 400. Flace Ul II	itc. (Specify)	m, street, factory, office		City or Tov		nutal Adult Nutriber,	
	To the Hospital or Attending I within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	Medical C	29a. Certifier Certifier (Check only 2 Medicone)	rying Physician: To the best cal Examiner: On the basis and manners	of examination and	, death occurred at the ti d/or investigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)	
	To the within 2 To the complex	Me	29b. Signature and title of cert	1		29c. Licens	se number	2	29d. Date signed (Mo	nth, Day, Year)	
)			Xlid	0)105m	06	DX	815dC		1/2/0	6	
-	- 8+1		30. Name and address of pers				, Will 84	` D 21962			
- 1		atė	31. Date filed (Month, Day, Ye		trar's Signature	y 31., 3110V	A LITTLY IAI	D 21003			
	Renist		100 0	3 2006	A	March a					

WAIGHT, 505EPH

			Please 1		Indelible Ink. Ensure Appartment of Health and I	=	•	
		1	For State Registrer	-	Pertificate of Death		NOTAL ALD) I
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 3. Time of Di	ath
	Physicia /Medic		Josen	ph Wright		SANUARY	01 2006 3	D _M
	Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Deat	h [4c. County of Death	
			ManoKin Ma 5. Social Security Number 6. Sex			nne 8. Date of Birth	Somevset	oreian
	Funeral Director			2□F 8 4 Yrs	Months Days Hours Min.	(Month, Day, Y	(ear) 9. Birthplace (State or F Country) Maryland	oreign
	ט		Usual Residence of Decedent					
	show		10a. State 10b. County Maryland Somers	10c. City Town or	acess Anne,		10d. Inside City	
	the M	Director	Maryland Somers 10e. Street and Number		10f. Zip Code	100	. Citizen of What Country?	
	72 hours after death with the Maryland *naturel', or Items 23a or 28e-f show folical Examiner must be notified at	ig l	11974 Edgeh.	11 Terrace	21853		U.S.A.	
	ems 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. 1 Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No-	14. Race - American Indian, Black, White, etc.	
36	or It	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Tes 2 No	1 ☐ Yes 2 ☑ No Specify:	, , , , , , , , , ,	Specify: Black	
Maryland 21215-0036	ture!	ed b	15. Decedent's Edu	Year or Dates:	ecedent's Usual Occupation	16	bb. Kind of Business/Industry	
215	S - 2	plet	(Specify only highest grade	College (1-4or 5+)	ive kind of work done during most of wor e. DO NOT use retired)	rking		
21	filed with Hygiene. Ithar thai	Completed	10th grade	Ca			Taxi Service	
nd	o d ita	Be	17. Father's Name (First, Middle, Last) John Wright			ne (First, Middle, Ma J AJEV		
ry la	2 should be and Mental is marked sumatic ev	²	John Wright 19a. Informant's Name/Relationship (Ty	(ne Print) 19h M	ailing Address (Street and Number or Ru	1		
Ma	s 1 and 2 should f Health and Mer item 27 is marke other treumatic	K 3	Mary Curtis /d	aughter P	0 0	lano Kin	md 21836	
Jre,	ges 1 and 2 t of Health a ff item 27 is or other trei	1	20a. Method of Disposition		sposition (Name of crematory or other place)	Date 20	c. Location - City or Town, State	
im	Pages ment of I ent: if it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	removal from State	of Crematory 1	13/06	Salisbury, md	
Baltimore,	permit. Pag Department Importent: f any injury o		21. Signature of Fundral Service License	90	2. Name and Address of Facility	Atheny E. U	Ward F. A.	0.000
	707 e a		230 Bod 1 Epor the disease or compli	inations that burned the death. Do not	30639 Hampolen	Ave, Thin	t. Approximate	33
		E.	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	A	enter the mode of dying, such as cardial	or respiratory arrest	Interval Betwee	en ath
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of):				
	Examiner		Conventingly line conditions	GVI				
	₽ .≅	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unease or injury	Due to (or as a consequence of):				
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of):				
760,	le be executed ysician and e burial-transit	calE		and to (or as a consequence or).				
687	The law requires that the death certificate to has been signed by the attending physbage 2 should be detached for use as the	edic		1.				
Вох	h cert ending	M/us	230. was decedent pregnant	23c. If yes, outcome of pregnancy 1□Live birth 2 □Fetal death	3 Ectopic pregnancy		23d. Date of delivery	
	e deat he att	Physician/Medi	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of death	5 Other (specify)		Month Day Yea	ir
P.0	that the de ed by the dedetached		9 ☐ Unknown Part II. Other significent conditions cor	cco use contribute to the cause of dea	th?			
Records,	uires tha signed id be de	d by	Tarkii Gillar digillilarii aanaa aa	mounty to down but not rooming in the	o and onlying daddo given in Fair i.	1 ☐ Yes		
cor	w require been si should I	lete				24a. Was an	24b. Were autopsy findings ava	ailable
Re	The lav	Completed				autopsy performe 1 \(\text{Yes} \) 2 \(\text{\$\sqrt{9}}	prior to completion of caus	e of
of Vital		BeC	25. Was case referred to medical examiner?		26. Place of Dea	ath (Check only one)	2110	
∑ V	Physic this ce rat direc	To	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa			ce 6 Other (Specify)	
o uc	ding P h. After t funera	ion:	27. Manyer of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injury		28d. Describe how	injury occurred	
Division	death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm,		28f. Location (Stree	et and Number or Rural Route Number	r.
Div	of or / s after il Dire	Certification:	4 Homicide	building, etc. (Specity)		City or Town, S	State)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director, I	edicai C	29a. Certifier 1 Cartifying Physical Examination	sician: To the best of my knowledge, d	eath occurred at the time, date and place r investigation, in my opinion, death occu	and due to the caus	se(s) and manner as stated.	
	the H hin 24 the F nplete	Medi	one)	and manner stated.				
	To To		29b. Signature and title of certifier		A. DO UU	290	I. Date signed (Month, Dey, Year)	
			30. Name and address of person who co	ompleted cause of death (Item 23a) (Tv	pe. Print)		17/	
			vef	VATESAN 1	29c. License number 0 470 44 pe, Print) 415 5. DIVISION SV	SALIST	3 v Ry MD 21804	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	1 ~			
	Registi	rar	JAN 0 3 2	JUD Klosen St.	COSE!			

	AVIE	na tem :	#11&19a	Per :	INF C8	54fiqat <u>9</u> 3	708°3#)		eg. No.		Oloce	
ysician ledical	Clifton L	eapold W	illiams					1	2. Date of Dea Month	Day	2006	3. Time of Death	
aminer	4a. Facility Name (If n Washingto	-				4b. City, Tow Hagers	m, or Location COWN	of Death			unty of Death shingto	on	
eral ctor	5. Social Security Nur 225–23–82	.31	x 7. X M 2□ F	Age (In yrs. 53	last birthday) Yrs.	If Under 1 Y. Months Da	ear ff Unde ays Hours	Min.	8. Date of Birth (Month, Day, 06/03/19	Year) 952	9. Birthp Coun	lace (State or Fore try) Jamaica	
De la la la la la la la la la la la la la	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Washington Hagerstown								10d. fnside City L				
Director	10e. Street and Numb	10f. Zip Coo 2174			1	1 √ Yes 2 □ No 10g. Citizen of What Country? US							
eumatic event, tra Mudical Examinar must be residied at To Be Completed by Funeral Director	11. Marital Status 1 Never Marriec 3 Widowed 4	d 2∏ Married	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? [X No		Was Decedent ff Yes, specify (of Hispanic O Cuban, Mexica	an, Puerto F					
r, tra Medical	(Specify Elementary/Second	(Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) S						dent's Usual Occupation 16b. Kind of work done during most of working 200 NOT use retired)					
To Be (17. Father's Name (F	irst, Middle, Last)						er's Name	(First, Middle, I	Maiden Sur	mame)		
other treumatic	19a. Informant's Nam	ne/Relationship (T)	урө, Print) / Wife		19b. Maili 131	ng Address (St Blooms .	Avenue	er or Rura Hage	Route Number erstown	City or To	own, State, Zip 21740	Code)	
-		osition Cremation 3 1		ate		osition (Name of matory or other rg Crem					ion - City or To		
ony injury o	21. Signatur: 31 Fune			2	22	2. Name and A	ddress of Facil	lity Ge	rald N.	Minn	ich Fun	eral Hom	
ian ical	231. Part1. Enter the shock, or heart fmmediate Cause (Fi disease or condition resulting in death)	failure. List only o	one cause on eac	h line.	th. Do not en	ter the mode of	dying, such as	s cardiac o	. ,	est,		Approximate Interval Between Onset and Death	
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			Stete Registrar			Cer	tificate	of De	eath		Reg. N	2006	0/323
	Physicia	an	1. Decedent's Name (First, Middle, Last		CKLIN	VI E				2. Date Monti	of Death	ay Year	3. Time of Death 2:35 рм
	/Medic	al	KEITH AI 4a. Facility Name (If not institution, give			N Li	4h Ciby To	wa orlo	cation of Deal	<u>Jan</u>	-	2006 tc. County of Deal	
	Examin	er	2015 Paulette H		ot. 3			Ltim				Baltimo	
	Funeral		Social Security Number 6. Se	9x 7. A	ge (In yrs. la:	st birthday)	If Under 1	Year If	Under 24 Hrs Hours Min	8. Date	of Birth h, Day, Yea		hplace (State or Foreign
	Director		216-/2-/220	M 2□F	43	Yrs.	WOTTE	Days	10urs Will	Dec	27,1	962 Mai	yland
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	Mary -f sho	ţŏ	MD Balti	more			В	alti	more				1 X Yes 2 No
	n the	Funeral Director	10e. Street and Number				10f. Zip C				10g. 0	Citizen of What Co	ountry?
	23a c	aiD	2015 Paulette 1	Road, Ar	pt. 3			212	22		U	nited S	tates
	tama term	nue	11. Marital Status	12, Was Decedent Armed Forces	?	. 13. V	Was Decede f Yes, specif	nt of Hispa y Cuban, N	anic Origin? (S Mexican, Puer	Specify Yes to Rican, etc	or No- c.)	14. Race - Ame Black, Whit	
36	rs eft	by F	1 Never Married 2 Married 3 Widowed 4 Moivorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		1	1 ☐ Yes 2	No S	Specify:			Specify: W	hite
Maryland 21215-0036	d within 72 hours effer death with the Maryland sien. Island. Than "natural", or Itama 23s or 28s-(show the Madical Examination must be notified at	ted	15. Decedent's Edi	ucation		16a. Deced	lent's Usual	Occupatio	n		16b.	Kind of Business/	Industry
215	thin 7 e. en "n Med	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or	5+)	lite. L	DO NOT use	retired)	ng most of wo	nking			
21	77 75 1- 1-		10			P	ainte			457		onstruc	tion
and	e d fa	Be	17. Father's Name (First, Middle, Last)					1	. Mother's Na			,	
2	2 should and Men is marke sumatic	ဥ	Tommy Wicklin 19a. Informant's Name/Relationship (7)			19b. Mailin	a Address /					ickline or Town, State, 2	Zin Code)
	od 2 lith a 27 is		Evelyn C. Wick:		her							ore, MD	
re,	s 1 and 3 of Health Item 27 other tr		20a. Method of Disposition		COL	ce of Dispo	sition (Name	of		Date		Location - City or	
Ë	mit. Pages bertment of floorients if its cortent: if its injury or or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		θ				er y 1,	/6/06	Fe	ederals	burg, MD
Baitimore,	permit. Pag Depertment Importent: I eny injury o once.		21. Signature of Funeral Service Licens	500		22 F r	Name and	Address o	Facility F	edera	1sbu	g, Mar	yland
	20 E # 0		Michael to	Them								1	Approximate
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
	Physician /Medical		Immediate Cause (Final disaase or condition resulting in death)	a. Due to (or a:	ing	Conc	er						6 months
	Examiner			. Due to (or a:	s conseque	ence of):							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying										
	ecuted and transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c									
60,	ate be executed hysicien and the burial-transit	cal E)	Tossiang in doubly East	Due to (or as	s a conseque	ence or):							
68760,	death certificate be executed e attending physicien and od for use es the burial-transit			d									
Вох	leath certifical attending phy I for use es th	υ/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date of del	ivery
œ.	death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant a 9□Unknown]Ectopic pred] Other (spec					Month	Day Year
P.0	that the de ed by the a detached i	Physician/Med	9 Unknown										
ls,	8 G 9	by	Part II. Other significent conditions co	intributing to death	but not result	ting in the ur	nderlying cau	ise given ii	n Part I.		Did tobacco		the cause of death?
Š	w requir been s should	etec								-	•	~	
Records,	The lav ete has page 2 :	Completed									Was an autopsy performed?	prior to o	topsy findings available completion of cause of
		8	25. Was case referred to medical					26	6. Place of De			lo 1 ☐ Yes	2 No
Ţ	di is	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpat	tient 2 E	R/Outpatien	t 3 DOA	Othor				6 ☐Other (Spe	cify)
	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inj (Month, D	jury Jay Year)	28b. Time of Injury	280	. Injury at Work?		28d. Desc	ribe how in	jury occurred	
sio	r Attanding ter death. Iractor: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be		Diver At bee		M		2 No	201 1 2221	ion (Ctmat	and Number of O	
=	after after Direct	Certification:	4 Homicide determined	28e. Place of Ir building, e	etc. (Specify)	ne, iarm, str	eet, lactory,	эпісе			or Town, Sta		iral Route Number,
_	To the Hospital or within 24 hours after To the Funeral Director completely filled in b		29a. Certifier 12 Certifying Phy	ysicien: To the bes	st of my know	ledge, death	occurred at	the time,	date and place	e, and due to	the cause	(s) and manner as	stated.
	the Ho in 24 the Fu pletel	Medical	one)	niner: On the basis and manner s	of examination	on and/or inv				urred at the			
	To the within 2 To the complet	2	29b. Signature and title of certifier.	111	m		1	License nu			29d. D	Date signed (Monti	2 /
			· Conc co	unjus	VII			LT:	200		da	new s	4006
			30. Name and address of person who d	/	death (Item :	23а) (Туре,	911. A	ELA	all con	C A	B	1 21L	37
	Sta	ite	31. Date filed (Month, Day, Year)	32. Reģis	trar's Signatu	ıre	1109	,,,	17-62	0		-1 0.	
	Registr	-	JAN 62	006	3.011 00 0	M. 1	Carte)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 24a per mr 9851 1-20-06 yt
State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** WIGGINS JENNIE RELLE2006 1312 M Jan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto losp:tal Balt of Dinai mora (If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT . 29, 1919 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1□M 2∯F Months Hours Min 230-03-5669 Yrs VIRGINIA Director 86 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 le marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Exactinar traumatic event, the Madical Exactinar traumatic event. 1XYes 2 □ No Director MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A.21229 155 SOUTH AUGUSTA AVENUE Funeral Was Decedent of Hispanic Origin? (Soecify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Bfack, White, etc. within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Ď Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) POST OFFICE MAIL CARRIER 11 filed Maryland 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or othar traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) Be MARY ANNA NICKENS TOMLIN WARNER TOMLIN ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 155 SOUTH AUGUSTA AVENUE BALTIMORE MD. 21229 WILLIE EDWIN WIGGINS (SON) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State LANCASTER VIRGINIA 22503 WILLIE CHAPEL CHURCH 1/8/06 4 □Donation 5 □Other (Specify) BERRYO. WADDY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility any Ir 6784 MARY BALL ROAD LANCASTER VIRGINIA 22503 O. Wall 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each fine. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PITCOUT 1000 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit and Due to (or as a consequence of): Box 68760. pe Physician/Medical the The law requires that the death certificate attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown been signed t should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cete has autopsy performed certificete Division of Vital 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA ၉ 1 ☐ Yes 2 No 1 Inpatient this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide hours after within 24 hours a To the Funaral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 4,2006 Jam BS 9316527 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7 smith Matthew 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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			1 - For State Registrar	State of Marylan	d / Depar			ental Hygie		01325
			1. Decedent's Name (First, Middle, La	ist)				2. Date of Death		3. Time of Death
	Physic /Medi		ZENOLIA N/M/	N WEST				Month JANUARY	Day Year 1, 2006	6 4:15A M
	Exami		4a. Fecility Name (If not institution, gir	re street and number)		b. City, Town, o	Location of Death		4c. County of Deat	
			HOLY CROSS HO	SPITAL			R SPRING		PRINCE (GEORGE'S
	Funeral			Gex 7. Age (In yrs. 1 1 ☐ M X ☐ F		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birt	hplace (State or Foreign untry)
	Director		Usual Residence of Decedent					AUG.5,1	920 VI	RGINIA
	J within 72 hours after death with the Maryland Jiene. r then "natural", or iteme 23a or 28e-f ehow I're Medical Exanton tre notified at	ctor	MARYLAND CHAR		y, Town or Loca LA PLA					10d. Inside City Limits 11 Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?
	23a	ai	1005 EASTBOURN	E DRIVE		206	46		U.S.A	• <i>F</i>
	er de	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Wa	s Decedent of H es, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	or i	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2∑ No If Yes, Give Year or Dates:	10	Yes XXNo	Specify:		Specific	
8	hour	ed	15. Decedent's E		16a Deceder	nt's Usual Occup	ation	16	b. Kind of Business/	LACK
5	C 3	Completed	(Specify only highest gr	ade completed)	(Give kii	nd of work done of NOT use retired	during most of working	19	b. Kind of Business	industry
21215-0036	filed within Hygiene.	E	Elementary/Secondary (0-12)	College (1-4or 5+) 4	LIBRA	RTAN		C	OMMIINITTY	COLLEGE
פ	m = 0 =	BeC	17. Father's Name (First, Middle, Las.)			18. Mother's Name			CODDIO
<u>lar</u>		10.	LENWOOD WALK	ΞR			MAGNOLI	A H. CR	UMP	
Maryland	2 should and Mer ie marks	ľ	19a. Informant's Name/Relationship	Type, Print)	19b. Mailing	Address (Street	and Number or Rural	Route Number, C	ity or Town, State, 2	Zip Code)
	12 g g		EMILY WALKER-				DURNE DR		ATA, MD 2	20646
ore	80 = 5		20a. Method of Disposition X X X Burial 2 ☐ Cremation 3 [lace of Disposit emetery, crema	ion (Name of tory or other plac	Da	ate 20	c. Location - City or	Town, State
Baltimore,	Pa Firt:		4 ☐ Donation 5 ☐ Other (Speci	MARYLAI	VET ON	ERAN'S	CEM. Ol	-09-06	CHELTENE	HAM, MD
<u>a</u>	Depenti Depenti Importa eny inj		21. Signature of Funeral Service Lice	M00479		Name and Addres	ss of Facility FUNERAL	CEDVICE	D 7	
	7 □ 2 • 0		23a. Part1. Enter the disease, or con	(2					-	
1	Pnysician /Medical Examiner		shock, or heert failure. List only Immediete Cause (Final disease or condition resulting in death)	one cause on bach line. a	OUER	LLOAL	FAILUR			Approximate Interval Between Onset and Death
/ '00'	te be executed ysicien and le burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence. Due to (or as a consequence)						
68760,	<u>~</u> ~ ~	dical		d						
. Box	ie death certificat the attending phy hed for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetel 4 ☐ Pregnant at time of de	death 3 □E	ctopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
0.	The law requires that the de ste has been signed by the a page 2 should be detached i		Part II. Other significant conditions	contributing to death but not rec-	ulting in the und	arlying cause a	an in Part I	23e Did tobac	co use contribute to	the rause of death?
ds,	signe signe	þ	PNEUMONI		and and	onlying cause give	minirani.	1 ☐ Yes		bably 4 Tunknown
Ö	w require been sig should b	Completed	12					-	29,10	- Olikiowii
ě	elaw hasi	ld m	ANEMIA					24a. Was an autopsy	prior to c	topsy findings available completion of cause of
<u></u>								performed		2 No
of Vital Records,	Physician: The Is this certificete ha ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		all DOA Othe	26. Place of Death			
ō	Phy this	P.	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	3L DOA	4 Nursing Hom		e 6 Other (Spec	eify)
Division	Jing After fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) n	Injury	M 1□	yat ⟨? Yes 2 □No	8d. Describe how i	injury occurred	
ā	ei or Att s after d ii Direct id in by	Certification;	3 ☐ Suicide 6 ☐ Could not to determined		me, farm, stree	t, factory, office	2	8f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
	To the Hospitei or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical (29a. Certifier (Check only one) Certifying P	nysician: To the best of my knowniner: On the basis of examinat and manner stated.	wledge, death o tion and/or inves	ccurred at the time stigation, in my or	ne, date and place, ar pinion, death occurre	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	0		29c. License	number	29d.	Date signed (Month	. Day, Year)
	->-0		· The	~ 14D		200	6334		103101	5
	N		30. Name and address of person who	completed cause of death (Item	23a) (Type, Pri					
	1			.D. 1500 FOR			,SILVER	SPRING	MD 209	10
	Sta		31. Date filed (Month, Day, Year)	2006 32 Registrar's Signal		Mes				· · · · · · · · · · · · · · · · · · ·

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Americal Ten 21 per 1h 9851 1-20-06 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** WILLEY 04:59 , 2006 anuary /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE Baltimore Hopkins pital HOS ohns 8 Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number **Funeral** Min. Months Days Hours 1XM 2□F 297-30-8004 OHIO Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner roust be notified at 1 ☐ Yes 2 🗖 No YORK Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code SH 2191 17402 ROAD FINEVIEW or Items 23a 12. Was Decedent Ever in U.S. Amed Forces?

1 X Yes 2 No If Yes, Give Year or Dates: 1458 to 1964 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Item 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (1-4or 5+) Elementary/Secondary (0-12) MANAGER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be PAUL VANORSDALE WILLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ROAD, Date YORK 17402 it of Health WILLEY WIFE FINEVIEW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State JANUARY 10, 2006 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. YORK * 4 □ Donation 5 □ Other (Specify) CREMATORY Pa. 17403 Ca. Paper Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, roximate Immediate Cause (Final 22. Name and Address of Facility 902 Mt. Rose Ave Immediate Cause (Final disease or condition resulting in death) Pnysician ardiovascular 11apse hour /Medical Due to (or as a consequence of) **Examiner** acrtic Sequentially fist conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit 901 requires that the death certificate be execu Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown sease page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 🗆 Yes 2 No o the Hospital or Attending Physician: the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Impatient 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification; After 1 Tatural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d, Date signed (Month, Dev. Year) 29b. Signature and title of certifier -000 1 ommen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Baltimore, Santosh 600 Dommen North Wolfe 32. Raistrar's Signature 31. Date filed (Month, Day, Year) State 2006 0 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2006 NORBERT BERNARD ZEZULEWICZ January 1, 5:10 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2 Castletown Court Waldorf Charles 8. Date of Birth (Month, Day, Year) Jan. 19, 1 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1X M 2□ F Months 160-22-4474 1928 Pennsylvania Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, Ite Modical Examinar must be notified at 1 ☐ Yes 2 X No Maryland Charles Waldorf Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 2 Castletown Court 20602 USA permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or incomplete. 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 No Specify: White þ Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Repairman Televisions 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Stephen Zezulewicz Selma Kulbacki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Castletown Court, Waldorf, MD 20602 Anna T. Zezulewicz - Wife 20a. Method of Disposition
1 IXBurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1-7-2006 St. Stanislaus Cem. Pittsburg, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses M01246 3035 01d Washington Road Huntt Funeral Home POB 156, Waldorf, MD 20604 ac 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final disease or condition resulting in death) CANDIOVASCULAR **Physician** 105CL92017C /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physiclan/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year detached for in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 1 Yes 2 No 2 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip Wisotsky, 12070 Old Line Center #207, Waldorf, MD 20602

Glied (Month, Day, Year)

32. Registrar's Signature 31. Date filed (Month, Day, State Colores . Registrar

06-00169 Amend item#23,27,28 1, perff, 6801, 1/25/06 11 B.K.S MAURICE ASHTON State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2006 **Physician** JAN. Maurice Ashtan 0344 A M /Medical Facility Name (If not institution, give street and number)
PRINCE GEORGES HOSPITAL CENTER 4b. City, Town, or Location of Death 4c. County of Death Examiner CHEVERLY PRINCE GEORGES 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F 218-11-0354 Director Line 14, 1984 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Maryland Prince George's 1 √Yes 2 No Directo Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 701 East Swan Creek Road 20744 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 □ Yes 2 □ No If Yes, Give X Year or Dates: 1X Never Married 2 Married ò Baltimore, Maryland 21215-0036 1□ Yes 2□ No þ Specify: Specify: Black 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Representative permit. Pages 1 end 2 should be filed v Department of Heelth and Mental Hygias Important: if Item 27 is marked other tt any injury or other traumatic event, the 2002. 2 Years Best Buy 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Josephus Ashtan Jr. Vera Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vera A. Ashton (Mother) 701 East Swan Creek Road Fort Washington, Maryland 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Resurrection Cenetery 01–13–2006 Clinton, Maryland 22. Name and Address of Facility Rollins Funeral Home, Inc. 21. Signature of Funeral Service License 4339 Hunt Place, N.E. Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Acute Ethanol Intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical esn IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. \$ this certificate has been siral director, page 2 should Completed 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 No 24a. Was an autopsy performed? Yes 2□ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 □ No 2 TER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of InjurFnd (Month, Day Year) Certification: 28b. Time of **Fnd** Injury 28c. Injury at Work? 28d. Describe how injury occurred unk After 1 Natural 5 ☐ Pending death. 1 Yes XX No investigation 1/7/06 2:58 A filled in by the f 2 . Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 931 St. Michaels Dr. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral D completely filled i Found in dwelling Mitchellville, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E JAN. 7, 2006 cause of death (Item 23a) (Type, Print)

AOL 111 PENN STREET, BALTIMORE, MARYLAND 21201 30. Name and address person who come Misns

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 17 per th g851 1-31-06 vt. State of Maryland 7 Department of Health and Mental Hygiere

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Januan 11:55 PM 200G Barbara M. Andresky /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hespital of Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 201F Yrs Director 1/10/1929 032-20-8252 Massachusetts Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other then "natural, or items 23a or 28a-f showers, the Medical Examiner cust be notified at 1 ☐ Yes 2 No Director Catonsville MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6107 Northdale Rd. 21228 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 Z No ģ Specify 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fi Depertment of Health and Mental I-Importent: if item 27 is marked of any injury or other traumatic even QDGS. Pages 1 and 2 should be ment of Health and Mental William MacLeose Lena Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Andresky - Husband 6107 Northdale Rd. Catonsville, MD 21228 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriai 2 Cremation 3 Removal from State 1/23/2006 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National Baltimore, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Dema 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death myocamios **Physician** /Medical Examiner Atheroschente Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the deeth certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of) Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 moeths 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) O 9 Unknown 9 ☐ Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pege 2 s autopsy performed? Yes 2.2 No certificete 10 No 1 Yes 1 Yes : After this certifice e funeral director, f Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐Yes 2☐No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manne of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after dea... ral Director: After 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signatuse and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) VASSILIADES SINAI HOSPITAL OF

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760, <

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Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 eny injury or other tr once.		20a. Method of Disposition 20b. Place of Disposition (Name of Date of Disposition (Name of Date of Disposition (Name of Date of Disposition (Name of Date of Date of Disposition (Name of Date	te 20	c. Location - City or To	own, State
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P.0	that the de ed by the detached	Phy	9 Unknown			
Ś	es pe	b	rath. Other significant conditions continuously to death but not resulting in the underlying cause given in Part i.		cco use contribute to the	\
ord	w requir been si should	ted		1 _ Yes	2 No 3 Prob	pably 4 Unknown
Record	elawr hasbe je 2sh	Completed		24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
<u>ж</u>		Con		performe	d? death?	20 No
Vital	sicien: Th certificate rector, pag	Be (25. Was case referred to medical 26 Place of Death (Check only one)		
of V	S S	0	1 ☐ Yes 2 ▼No Hospital: 1 ☐ Inpatient 2 → VOutpatient 3 ☐ DOA Dther: Nursing Home	5 Residence	e 6 ☐Other (Specif	y)
п	ding P			d. Describe how	injury occurred	
<u>si</u>	death.	atl	2 Accident investigation M 1 Yes 2 No			
Division	ol or Attence after death Director: d in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
	itel c					
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the caus at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)
	o the ithin 2 o the omple	Med	29b. Signature and title of certifier 29c. License number	29d	. Date signed (Month,	Day, Year)
	F ≯ F 8		David 50 03227			
7	121) 1	Dunay 1	4, 2006
	61		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID DUNN - 615 W. MACPHAIL ROAD - BEL AIR, MD 2101		U	
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	т		
	Registi		100100000000000000000000000000000000000			

			For State Registrar	State	of Maryla		artmen <i>rtificat</i>					giene Reg. No.	306	013	33
			1. Decedent's Name (First, Middle	, Last)							2. Date of De Month	ath Day	Year	3. Time of	Death
	Physici: /Medic		Anita Baker								Januar		2006	10:12	AM ^M
}	Examin		4a. Facility Name (If not institution	, give street and i	number)		4b. City,	Town, or	Location of	of Death		4c. Co	unty of Death	1	
			4828 Park H	eights A	venue				timo						
8	Funeral		5. Social Security Numberunk	6. Sex 1 ☐ M 2 ☑ F		rs. last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th ly, Year)	Con	place (State o untry)	r Foreign
-	Director				48	Yrs.					Jan 27	, 1957	Mary	land	
	and *		Usuel Residence of Decedent 10a. State 10b. County		10c.	City, Town or Lo	ocation							10d. Inside Ci	ty Limits
	Aaryli sho	٥			D.	altimore								1√ Yes	2 🗆 No
	28a-1	Directo	MD 10e. Street and Number		De	al L TIMOT (10f. Zic	Code				10a. Citizen	of What Cou	71	
	with with		4828 Park Heig	this Ave	กนค			2121	15				USA	,	
	eath	Funerai	11. Marital Status		ecedent Ever in	U.S. 13.	Was Dece			igin? (Sp	ecify Yes or No	- 14.	Race - Amer	ican Indian,	
	ter d	F	1 Never Married 2 Marr	Amed	Forces?		If Yes, spe	cify Cuba	n, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)	1	Black, White		
ğ	urs a	by	3 ☐ Widowed 4 🏋 Divorced	If Vac	Give r Dates:		1 🗆 Yes	2 ∏ No	Specify:			Sp	ecity: bla	ack	
Ž	ould be tiled within 72 hours atter death with the Maryland Mental Hyglene. arked other than "natural", or items 23s or 28s-f show atto event, the Medical Exantral must be notified at	Completed	15. Deceden		ad)	16a. Dece	dent's Usu	al Occupa	ation	t of work	una.	16b. Kind	of Business/I	ndustry	
2	hin 7	pie	(Specify only higher Elementary/Secondary (0-12)	1	e (1-4or 5+)	life.	DO NOT u	se retired)			_			
2	ifited with Hygiene. other ther	NO.	10		0		hea1	th ca	are p				nealth		
2	should be filed within and Mental Hygiene. marked other than matic event, the Mental and the matic event, the Mental and the matic event, the Mental and the matic event, the Mental and the matic event, the Mental and	Be (17. Father's Name (First, Middle,						18. Mothe		First, Middle		mame)		
<u>a</u>	should tind Ment	ဂ္	John Bak	er						ма	ry Edwa	ras			
Maryland 21215-0036	es 1 and 2 should to Health and Ment (Item 27 ie markeer rother traumatic er		19a. Informant's Name/Relations			1	_				Al Route Numb	-			207
≥	and eaith n 27 rer tr		Mary Dunn/mothe	er	1				Garde		ne 321B				.207
altimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐ Removal fro		 Place of Disponentery, cre 	matory or o	ne of other plac	e)	ı	Date	20c. Locati	ion - City or T	Town, State	
Ĕ	Peges ment of ent: If it ury or o		' 4 □Donation 5 XOther (S	pecify) in s											
at	permit. Peges Department of Importent: If I any injury or once.		21. Signature of Euneral Selvice Ronald	Licensee Wade	Divect	or s	2. Name ar	d Addres	ony B	bard	655 W.	Balt:	imore	Street	
<u>m</u>	895 # 9		/ man	1/1/10	Wel-	→ B	altim	ore,	MĎ	2120	1				
A LOCALIDA	Physician /Medical Examiner property of the privariation and property of the privariation of the privariat	Examiner	23a Part 1. Exter the disease, or shock, or heart failure. List immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if a y, leading to monodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due	to (or as a cons	sequence of):	Tue	A Sugar	sol F	lisa	tus en c	<i>y</i>		Interval Bet Onset and I	
8760,	ate b	dical		d											
O. Box 68	death certific e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Liv 4□Pri	outcome of preve birth 2 Feegnant at time on	etal death 3	⊒Ectopic p ⊒ Other (sp					23d	. Date of delin	,	Year
مز	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditi	ons contributing t	o death but not	resulting in the (underlying o	ause give	en in Part I	1.	23e. Did 1	obacco use	contribute to	the cause of c	leath?
ds,	uires sign Id be	d by									10	Yes 2□N	lo 3 Pro	obably 4 🗀	Jnknown
Record	w requir been si should	Completed									24a. Was	an 2	4b. Were aut	topsy findings	available
Re	0 - 0	m									auto perfe	psy prmed?	prior to c death?	completion of c	ause of
	ician: Th certificate rector, pag	e Co	25. Was case referred to medica		<u> </u>				OF Diagram	o of Doot	1 Yes		1 🗌 Yes	211NO	
Vital	ysician: is certific director.	8	examiner?	Hospital:	☐ Inpatient 2	P ☐ ER/Outpatie	at 3 🗆 🖂	Oth	AC		h (Check only only only only only only only only		Other (See	1464)	
o	Phys r this sral di	. To	27. Manner Death	28a. Da	ate of Injury	28b. Time o		28c. Injun	y at	ursing me	28d. Describe			луу	
on	iding F th: After funer	tlor	1 tural 5 Pendii 2 Accident investi	ng (N igation	Month, Day Year	r) Injury	м	Worl	k? Yes 2. ☐	No					
Division	of or Attending Physician: after death. I Director: After this certification by the funeral director.	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 289. Pl	lace of Injury - A uilding, etc. (Spi		treet, factor	y, office			28f. Location (City or To	Street and N wn, State)	umber or Ru	ral Route Num	aber,
	To the Hospitel or within 24 hours after To the Funeral Discomilately filled in	edicai C		ng Physician: To Examinar: On th and m											;)
	To the within 2 To the comilet	Σ	29b. Signature and title of certific			2 /	1/ 29	c. Licens	e number			29d. Date s	igned (Month	n, Pay, Year)	
)	F > F 0			224		Has	5	41	165	26	7-	1/1	6/0	6	
			30. Name and address of person	who completed of	cause of death (Item 23a) (Type	Physi	2	4		1,0	1	1		
			J. B. 11/1	evan	2	11 20	, 7	6/1	redi	lie	Hor	-13	alti	more	- MX
	St	ate	31. Date filed (Month, Day, Year		2. Registrar's Si	gnature	16	V							-
	Regist	rar	0 MM 6 0 7	Hib Me.	0 4	of the same	10 2								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#30, per 30 Amend TDepartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SHELDON BRAITERMAN JANUARY 18 2006 4:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3610 ETTEMILLER ROAD BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) AUG. 25, 1927 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 □ F 217-20-0314 78 Yrs. Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: if Item 27 is marked other then "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits wen zr is marked other then "natural", or items 23a or 28a-f show other traumatic event. Its Modical Executing main by nulliad at 1 No Yes 2 No Director N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 WHITFIELD ROAD 21210 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 IX Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Efementary/Secondary (0-12) Coflege (1-4or 5+) LAWYER LAW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **FEDDER** BRAITERMAN WILLIAM LEONA ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2. Department of Health a Important: if Item 27 is any njury or other traugonce. 20 WHITFIELD ROAD - BALTIMORE, MD 21210 MARILYN BRAITERMAN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM. 01/20/2006 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Euneral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the dis-shock, or heart fail ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest e. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate dause (Final disease or condition Alzheimens/ **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner They recitoris Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a consequence of) Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. ff yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown Part II_Other significant-conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by page 2 should be 1 ☐ Yes 2 Z No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 🗌 No 1 Yes 20 No Hospital or Attending Physician: After this certification 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospitaf: Other: 1 Yes 2 No Certification: To 1 Inpatient 2 EP/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No investigation 6 Could not be determined 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical (Chack only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Haylan 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dana H. Frank 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Department of Heelth a importent: If item 27 is any injury or other tre once.

Physician

/Medical

Examiner

physicien

use as the

cete hes been signed by the ettending page 2 should be detached for use as

After

within 24 hours efter death To the Funeral Director: completely filled in by the f

death.

Physician/Medical

þ

Be Completed

Medical Certification: To

or Attending Physician: The law requires that the deeth certificate be executed

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions,

in the past 12 months? 1 ☐ Yes 2 ☐ No

Onset and Death

23d. Date of delivery

Day

Year

Month

		Amen	id Unpend	1 1tem#2,23a	1,2/,28a-f	,perive,	3853,3/8/06	TT	Montal ⊟v	aionoo e	200	
	•	For State Registrar		1 item#2,23a State o	or ivial ylair	Се	rtificate of	Death		Reg. No.	106	01335
		1. Decedent's Nam	e (First, Middi	le, Last)				-	2. Date of De			3. Time of Death
Physician /Medical	-		HILLEL	<u>-</u>	YAAKOV		BEN-/	ΔMΙ	Janua:	cy 18,	2006	6:44 P M
Examiner	-	4a. Facility Name (i	f not institution	n, give street and nu	ımber)		4b. City, Town, o	r Location of Death		4c. Coun	ty of Death)
	ı	Good San	naritan	n Hospital	_		Baltimor	e				N/A
Funeral Director		5. Social Security N 209-46		6. Sex 1 M 2 □ F	7. Age (In yrs. I	last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da SEP. 16	, 1957	9. Birth Cou	place (State or Foreign intry)
ס		Usual Residence o	f Decedent									
ylan	- !	10a. State	10b. County	′	10c. City	y, Town or L	ocation					10d. Inside City Limits
with the Marylan or 28a-f ehow be notified at		PA		DAUPHIN		HARF	RISBURG					1 Ves 2 No
or 28	2	10e. Street and Nu	mber				10f. Zip Code			10g. Citizen o	f What Cou	intry?
23a c	<u>a</u>	1407 M	ONTFOR	T DRIVE				17110				USA
be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or iteme 23a or 28a-f ehow event, the Madical Exeminar must be notified at the Commission by Euraral Director.		11. Maritaf Status 1					Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)		ace - Ameri lack, White	, etc.
rai', or	5	1 Yes 2 X No If Yes, Give 3 Widowed 4 Divorced 1 Yes 5 ive Year or Dates:				1 ☐ Yes 2 💢 No		Specify: WH				
s 1 and 2 should be filed within 72 hour Heelth and Mental Hygiene. Item 27 is marked other than "natural" other treumatic event, the Medical Ex			cify only highe	nt's Education est grade completed		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of work	ing	16b. Kind of	Business/Ir	ndustry
filed withi Hygiene. other then ent, the M	5	Elementary/Seco	ondary (0-12) 12	College	(1-4or 5+)	1	ENT/DISABI			EDUCAT	ΓΙΟN	
Hygothe other		17. Father's Name	(First, Middle,	, Last)				18. Mother's Nam	e (First, Middle,	Maiden Suma	ame)	
2 should be and Mental is marked of bumatic every	3	DAVID		Z.		BEN-A	\MI	EVELYN				REISMAN
should and Men amarke umartic	1	19a. Informant's N	ame/Relations	ship (Type, Print)		19b. Mail	ng Address (Street	and Number or Rui	al Route Numbe	er, City or Tow	n, State, Zi	ip Code)
1 and 2 Heelth a em 27 is ther tre		DAVID	Z. BEN-	-AMI / FA	THER	1407	MONTFOR	T DRIVE -	HARRIS	BURG, F	PA 17	110
00	1	20a. Method of Dis		3 Nemoval from	n State	emetery, cre	osition (Name of matory or other place	ce)	Date	20c. Location	1	
Peg nent ent: I ury o	- 1	4 □Donation	5 🗌 Other (5	Specify)	KES	SHER I	SRAEL CEM	IETERY 1/2	20/2006	HAR	RISBU	RG, PA

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State KESHER ISRAEL CEMETERY 1/20/2006 HARRISBURG, PA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signatur of Funeral Service Licer

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Mich 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) Methadone intoxication associated with pneumonia

Due to (or as a consequence of):

Due to (or as a consequence of)

Due to (or as a consequence of):

r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

3 Probably 4 Munknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No

24a. Was an autopsy performed? 1 Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 XER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred 28a. Date of fnjury (Month, Day Year)

1 Natural 5 Pending Fnd 6:30 PM 1 Yes 2√ No 2 Accident investigation Fnd 1/18/06 6 XCould not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 5011 Harford Road 4 Homicide Found at residence Baltimore, MD

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Additional Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

miD OCME January 19, 2006

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 LING LI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Edward Brown 06-00392 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of Maryland / Depa	artment of Health and rtificate of Death		ene 006	01336
		1. Decedent's Name (First, Middle, La	st)		2. Date of Death		3. Time of Death
Physi		Educad B	rown		January	15 2006	1652 M
Exam	dical	4a. Facility Name (If not institution, gir		4b. City, Town, or Location of De		4c. County of Death	
- Andi		University Hospi	tal	Baltimore		N	/ /\
Funera	al	5. Social Security Number 6.	Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 H		9. Birth	place (State or Foreign
Directo		217-96-3206	100M 20F 24 Yrs.	Months Days Hours Mi	n. (Month, Day, 1) Mourch 7	5. 1981 Coui	MIN
D .		Usual Residence of Decedent		· · · · · · · · · · · · · · · · · · ·		211101	
nylar	_	10a. State 10b. County	10c. City, Town or Lo	4		'	10d. Inside City Limits
h the Maryland r 28a-f ehow	양	MD N/	A Balt	more			1 No Yes 2 No
ê ç 2	- ir	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cour	ntry?
death with the Maryland me 23a or 28a-f ehow гливт be notified at	Funeral Director	1016 E. Bel	vedere Avenue	21212		USA	A .
er death w Iteme 23e ret must t	ie i	11. Marital Status	12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No-	14. Race - Americ Black, White,	can Indian,
36 afte		1 Never Married 2 ☐ Married	1 □Yes 2 12/No	1 ☐ Yes 2 12 No Specify:			
5-0036 72 hours after death with "naturel", or Iteme 23e or	d by	3 Widowed 4 Divorced	Year or Dates:			Spacity. 1	ack
72 r 72 r	Completed	15. Decedent's E (Specify only highest gr	ade completed) (Give	dent's Usual Occupation kind of work done during most of w	orking	6b. Kind of Business/In	dustry
2121 ad within giene. er than	E G	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)		C - c -	10
1 2 Sign		17. Father's Name (First, Middle, Las.		-aborer	(First Middle 14	Constr	wetton
laryland 2121 2 should be filed within and Mental Hygiene. Io marked other than sumatic event, than	Be	17. Father's Name (First, Middle, Las.		18. Mothers N	ame (First, Middle, Ma	aiden Sumame)	
VIC	မှ	Lum Edward	3 rown		erry A	. Leslie	
Iltimore, Maryland 2121 iii. Pages 1 and 2 should be filed within artment of Health and Mental Hygiene. orlant: If Item 27 le marked other than injury or other traumatic event, tra Ms	010	19a. Informant's Name/Relationship	1	ng Address (Street and Number or I			
other tra		Latrica morgo		E. Belvedene		Baltimore	
OF ges		20a. Method of Disposition 1 Suburial 2 ☐ Cremation 3 €	Inemoval from State	natory or other place)	-	0c. Location - City or To	
Fant:		4 □ Donation 5 □ Other (Speci	w) Irinity	Temetery Janu	ary 21, 2006	Lansdown	e MD
Baltimore, permit. Pages 1 a Department of Hes Important: If Item	j G	21. Signature of Funeral Service Lice	/ 22	Emetery Janu. 2. Name and Address of Facility Har. P. Clos. 5126 Belant	Funeral	Service,	P. A.
m goes	OI .	A-(-)		5126 Belan	ROOD B	altimono M	90515 0
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the death. Do not ent	er the mode of dying, such as cardi	ac or respiratory arres	st,	Approximate Interval Between
Physicia	n	tmmediate Cause (Final disease or condition	Mulholy Or	unshot Wound	:		Onset and Death
/Medica		resulting in death)	Due to (or as a consequence of):	31.41.01			
Examine		Sequentially list conditions	b				
P #	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
acute	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c				
760, s be executed sicien and burial-transit	Ě	resulting in death) Last	Due to (or as a consequence of):				
8760, cate be evented by sicient the buria	dicai		d			<u></u>	
	(4)	IF FEMALE:					
Box 6 death certific death certific e ettending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of delive	*
C e e	2	1 Yes 2 No	4☐Pregnant at time of death 5☐ 9☐ Unknown	Other (specify)		Month	Day Year
- = >0	듄	9 Unknown		1			
ords, P.C. requires that the een signed by the ould be detected.	و	Part II. Other significant conditions	contributing to death but not resulting in the u	nderlying cause given in Part I.		cco use contribute to the	
cord w requir been s should	ted				1 🗆 Yes	2 No 3 □ Prob	bably 4 Unknown
Peco e law r has be	pie				24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
Division of Vital Records, at or attending Physician: The law requires their death. I Director: After this certificate has been signed in by the tuneral director, page 2 should be or	Completed				performe	ed? death?	2 □ No
of Vital F Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?		26. Place of D	eath Check only one	1	
ysic nis ce dire	ု	1√2¥es 2□No	Hospital: 1 ☐ Inpatient 2 X ER/Outpatien	it 3 DOA Other: 4 Nursing	Home 5 ☐ Residen	ce 6 ☐Other (Specif	(y)
ng Ph ter th	Ë	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
ath.	atic	2 Accident investigation	115/06 4:24	PM 1□Yes 2 No	subject	was shot	•
Yis ratte	t s	3 Suicide 6 Could not to determined		eet, factory, office	28f. Location (Stre	et and Number or Rura State) 1300 DIE.	I Route Number,
Distribution of the column of	Certification:	X	street		Balhmere	MN	et mosher St.
To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the tuneral	Cal	29a. Certifier 1 Certifying P	nysician: To the best of my knowledge, death	n occurred at the time, date and plan	e, and due to the cau	ise(s) and manner as s	tated.
in 24 in 24 he Fi	Medical	one)	miner: On the basis of examination and/or in- and manner stated.	vestigation, in my opinion, death oc	curred at the time, dat	e and place, and due to	o the cause(s)
To t To t	Σ	29b. Signature and title of certifier	.,	29c. License number	290	d. Date signed (Month,	Day, Year)
		Humita Gain	thail mo	OCME	Ja	nuary, 16,	2006
		30. Name and address of person who	completed cause of death (Item 23a) (Type,	Print)			
		Pamel E. Su	when, MD	111 Penn Stre	et Reltin	nore Maruil	and 21.201
	tate	31. Date filed (Month, Day, Year)	Registrar's Signature		Daltl	wee, raly 1	and Lizut
Regis	strar	JAN 2 1 200	6 Janes M. Age	GET .			

Dwight A. Dodge Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-0481 State of Maryland / Department of Health and Mental Hygiene AG Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month DWIGHT ALTON DODGE, JR. 19, 2006 9:40 P M January /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**万** M 2□ F Director Yrs 218-52-0114 58 7/25/1947 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location or itsms 23a or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director MD GARRETT 1 ☐ Yes 2 No OAKLAND 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 608 HARVEY WINTERS DRIVE Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
snt: If Item 27 Is marked other thsn "naturs!", or Itsms 23sury or other traumatic syent, the Medical Exemples must Funeral 21550 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2 X If Yes, Give Year or Dates: 2**X**] No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FUEL 4 YEARS OFFICE MANAGER 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) DWIGHT A. DODGE, SR. EVELYN BROOKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 HARVEY WINTERS DR. SHARON A. DODGE/WIFE OAKLAND, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of Important: If any Injury or once. METRO CREMATORY, INC. 1/25/2006 4 Donation 5 Other (Specify) CATONSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician INTUSCEREBBUSE HEMORRIANGE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (U. as a consequence of) Examiner use as the burial-transit Attending Physician: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 TYes 2 1No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available pnor to completion of cause of death?

1 4 es 2 No autopsy performed? 12 Yes 2 N certificete 2 🗌 No 25. Was case referred to medical examiner?

1 X Yes 2 □ No Be 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) s after deain.
at Director: After this Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation М 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 filled in To the Hospital within 24 hours a To the Funeral Completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

18

State
Registrar

MANA MATA

31. Date filed (Mohth, Day, Year)

JAN 2 3 2006

Monte

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

111 Penn Street, Baltimore, Maryland

O.C.M.E.

January 22, 2006

		For	State of Maryla	•			Mental Hy	giene 006	01338
	5)	State Registrar	41	Ce	rtificate of	Death	2. Date of Dea	Reg. No.	3. Time of Death
Physicia /Medic		Decedent's Name (First, Middle, Las LOUIS		DE	ITSCH		Month	Day Year	4 11:15 PM
Examin	er	4a. Facility Name (If not institution, give	street and number) Butting		12 11	or Location of De	ath	4c. County of Dea	N/A
Funeral Director	7	5. Social Security Number 6. Sec 220-14-0167	7. Age (In y	rs. last birthday,		If Under 24 H		^{9. Bi}	rthplace (State or Foreign ountry)
put		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
Manyla -feho	to		IMORE		IMORE				1 ☐ Yes 2 No
th the or 28e	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	
23a cast b	rai	4743 MARYKNOLL F				21208	10 11 11	14 5 1	USA
INCLA FILE 15-UU30 be filed within 72 hours after death with the Maryland and Hygiene. All Hygiene. Ad other than "natural", or Itame 23a or 28e-f ehow orent. It a Medical Examiner mans be mailfied at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 🂢 Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:	n U.S. 13.	Was Decedent of If Yes, specify Cub		(Specify Yes or No- erto Rican, etc.)	- 14. Race - Am Black, Wh Specify:	
72 hou	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	dent's Usual Occu	pation during most of w	vorking	16b. Kind of Business	s/Industry
Mithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)		AUTOMOBIL	F REPAIR
filled v Hygie other if	e Co	17. Father's Name (First, Middle, Last)		LIVIN	LINLINLON	18. Mother's N	lame (First, Middle,		L KEIMIK
vid be Mental rrked (To B	MORRIS		DEIT	SCH	MINNI	E		HOFFMAN
IIIIMOre, IMBITYIE iii. Pages 1 end 2 should eriment of Health and Mer ortant: if Item 27 ie marke injury or other traumetic is.		19a. Informant's Name/Relationship (7			•			er, City or Town, State, RE, MD 2123	
ore, IV of Health of Health of Item 27 ir other tr		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □		b. Place of Disp cemetery, cre	osition (Name of matory or other pla		Date	20c. Location - City o	
SAITIMOTE permit. Pages 1 Depertment of He important; if ten eny injury or oth		4 ☐ Donation 5 ☐ Other (Specify) Bi		EL CEMET		20/2006	BALTIMO	
permit Depert Import eny in		21. Signature of Funeral Service Citen	see		2. Name and Addr	~		SON & BROS. PIKESVILLE,	
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the cone cause on each line.						Approximate Interval Between Onset and Death
Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Airway		stion				2 Weeks
Examiner		- (Due to (or as a con		Carotion				2 1208
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a con		,				2 Days
acuted ind transil	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	G.	-ibrilla	reit				3 Day 8
3 / bU, ate be executed nysician and he burial-transit	cal Ex	resulting in death) cast	Due to (or as a con	sequence or):					155.5
58 / ifficate g phys		•	d						
beath certificat eattending phy d for use as th	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		□Ectopic pregnan	cv		23d. Date of de	
. 0 0 0	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time 9☐ Unknown		Other (specify)	<u></u>		Month	Day Year
– 2 2 8		Part II. Other significant conditions o	ontributing to death but not	resulting in the	underlying cause g	iven in Part I.	23e. Did t	obacco use contribute	to the cause of death?
COrdS w requires been sign should be	ed by						10'	Yes 2 □ No 3 □ F	Probably 4 Unknown
VI(al HECOrdS, sicien: The law requires t certificate hes been signe rector, page 2 should be o	Completed						24a. Was	prior to	autopsy findings available completion of cause of
							1 ☐ Yes	ormed? death?	s 28No
Of Vital Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 🗌 ER/Outpatie	27704 0	ther	Death Check only o	one) dence 6 🗍 Other (Sp	anti-l
g Phys er this eral di		27. Manner of Death	28a. Date of Injury (Month, Day Yea					how injury occurred	өспу)
VISION Attending r death. ector: After	atio	1 Natural 5 Pending 2 Accident investigation	1		M 1[]Yes 2 □No			
DIVISION C tel or Attending P s efter death. el Director: After ted ed in by the funera	Certification:	3 Suicide 6 Could not be determined		At home, farm, s pecify)	treet, factory, office	Ð	28f. Location (City or To	Street and Number or I wn, State)	Rural Route Number,
DIA To the Hospitel or. within 24 hours efter To the Funerel Dire completely filled in b	edicai (ysician: To the best of my niner: On the basis of exa and manner stated.						
To the within 2 To the complet	Me	29b. Signature and title of certifier	\supset			nse number		29d. Date signed (Moi	
			1	0	RE	es oc	00	January 1	8,2006
.30		30. Name and address of person who		(Item 23a) (Type 2 4 0 ((, Print)	eluo taro	Ave F	3e Himmer	8,2006 MD 21215
Sta	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's S		a = M &	142000		- wit 11" "W14"	

Certificate of Death

If Under 1 Year

Months

Days

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

022-03-1506

10a. State

Usual Residence of Decedent

Victoria Donahue

4a Facility Name (If not institution, give street end number)

Brook Grove Nursing Home

10b. County

6. Sex

1 □ M 2 🖾 F

Physician

/Medical

Examiner

Funeral

Director

Death	Re	g. No.	Ub	01339
	2. Date of Death Month January	Day	Year 2006	3. Time of Death 4:40pm
4b. City, Town, or L	ocation of Death	4c. C	ounty of Deet	h
Sandy Spr If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 18	Year)		y hplace <i>(State or Foreigr</i> untry) ssachusetts
				10d. Inside City Limits

1 ☐ Yes 2 ☐ No

7. Age (In vrs. last birthday)

10c. City, Town or Location

93

13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

Specify: White 16b. Kind of Business/Industry

Race - American Indian, Black, White, etc.

10g. Citizen of What Country?

United States

Clothing Company 18. Mother's Name (First, Middle, Maiden Sumame)

Anna (Unknown)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11009 Nicholas Drive Silver Spring, MD 20902
Date | 20c. Location - City or Town, State 01/20/06 Braintree, MA

22. Name and Address of Facility Sweeney Funeral Home 74 Elm Street Quincy, MA 02169

Approximate Interval Between Onset and Death

3 Probably 4 Unknown 1 TYes 2 kNo

23b. Did tobacco use contribute to the ceuse of death?

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

2 No 1 ☐ Yes

1 □ Yes 2 □ No

26. Place of Death (Check only one) Other: 4

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred 28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

> 29c. License number 133700

29d. Date signed (Month, Dey, Yeer) 16, 2006

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

18100 Slade School Rd., Sandy Spring, MD 20860 Ted E. Howe, M.D.

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

1 2006

32. Pygistrar's Signature

Soule

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year COPREL NAThaniel 2006 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Pastall town 401 1 homes Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 1 MM 2□ F Days 216-58-2412 Usual Residence of Decedent 10b. County 10a, State 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director ti more 10g. Citizen of What Country? 10e. Street and Numb 10f. Zip Code 21133 8669 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No ģ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry

Pages 1 end 2 should be filed within 72 hours after death with the Maryland raf, or iteme 23a or 28e-f ehow Express over be coulfied at Baltimore, Maryland 21215-0036 permit. Pages 1 end 2 should be filed within 72 ho Deportment of Health and Mental Hygiene. Important: If Item 27 is marked other then "natur any injury or other treumatic event, the Medical once.

Physician

/Medical

Examiner

Funeral

Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2:

Division of Vital Records, P.O. Box 68760.天

(Specify only highest grade	completed)	(Give kind of w	ronk done during most of wo	nking	
Elementary/Secondary (0-12)	College (1-4or 5+)		ver retired)	Tr	ansportation
17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First Middle, Maid	en Sumame)
John Evan,	Sr,		Mune	1 4h:llix	λs
19a. Informant's Name/Relationship (T)	pe, Print)	19b. Mailing Address	s (Street and Number or R	ura Route Number City	r Town, State, Zip Code)
Kim Y. Evans /	Wite	8669 W:	nands Rd.	Kardalla	nun mt 21133
20a. Method of Disposition	20b. l	Place of Disposition (Na cemetery, cremator) or	ame of	Date 20c.	Location - City or Town, State
1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	udonta	rk 1-3	26-06 B	iltimore, MD
21. Signature of Funeral Service License	1	22 100	MARINE FOR	pe tuner	1 Services
Maughn C. K	helne	8728	Sperty Rd. 1	Candallsto	wn, Mb 21133
23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the dea e cause on each line.	th. Do not enter the mo	de of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between
Immediate Cause (Final disease or condition			DAY VA	what do	Onset and Death
resulting in death)	Due to (or as a consec	quence of):	0012011	- (O)	470
Control of the line of the lin					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence oi):			
Cause (Disease or injury that initiated events					
resulting in death) Last	Due to (or as a consec	quence of):			
	I				
IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregn 1□Live birth 2□Fet	ancy			23d. Date of delivery
in the past 12 months?	4 Pregnant at time of €				Month Day Year
9 Unknown	9□ Unknown				
Part II. Other significant conditions con	tributing to death but not re	sulting in the underlying	cause given in Part I.	23e. Did tobacc	use contribute to the cause of death?
				1 🗆 Yes	2 No 3 Probably 4 Unknown
				24a. Was an	24b. Were autopsy findings available
				autopsy performed?	prior to completion of cause of death?
25. Was case referred to medical				1 Yes 2 1	To 1 □ Yes 2 ☑ No
examiner?	lospital:	3500		ath (Check only one)	
27. Manner of Death	1 Inpatient 2	ER/Outpatient 3	28c Injury at	Home 5 Residence	6 □Other (Specify)
1 ☐ Matural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	200. Describe now in	ary occurred
2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h			29f Lagation /Ctrant	and Number or Rural Route Number.
4 Homicide determined	building, etc. (Speci	ify)	ry, once	City or Town, Sta	and Number of Aural Houte Number, ite)
29a, Certifier 4 Certifying Phys	1-1 T- N b			1	
(Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	ation and/or investigation	d at the time, date and place in, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifier		2	9c. License number	29d. [Date signed (Month, Day, Year)
that III		offerding !	D41320) 5.	n 19, 2006
30. Name and addless of erson who co		m 23a) (Type, rint)	. 1 6 11	2.1 1.	41/1/bun, Md 21133
Housed mo	III MO	5401 6	12 cult 1	use 10m	Millom, Md 21133

State Registrar

Louald 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#17,perffl,GS1,1/23/16 TI
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 10:20 A Manuel Johnson Hidalgo Fernandez 16,2006 Jan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/AJoseph Richey Hospice Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs. Director 1959 123-56-0785 46 Dec. Ecuador Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow the Madical Exeminer must be notified at Y⊟Yes 2 No Baltimore N/AMaryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ecuador 21215 <u>3708 Glen Avenue</u> Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 "natural", or Specify: Hispanic 1 StYes 2 □ No Specify: ð 3 ☐ Widowed 4 € Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed permit. Pages 1 and 2 should be filed v. Depertment of Health and Mental Hygie Important: if Itam 27 is marked other ti any injury or other traumatic avent, the page. Auto Mechanic 12th grade 17 Father's Name (First, Middle, Last)
Gilbert 18. Mother's Name (First, Middle, Maiden Surname) Be Petita Hidalgo Gilberto Fernandez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3708 Glen Avenue Baltimore, Maryland 21215 19a. Informant's Name/Relationship (Type, Print) Yvonne B. Astwood /Fiance Itimore, Greenmount Cemetery 1/19/06 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Funeral Service Licensee Xkelen 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** yMphoma /Medical Examiner Immune Deficiency Syndrome VITED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien end s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ 3 ☐ Probably 4 ☐ Onknown 1 Tyes 2 No After this certificete hes been si funeral director, page 2 should i Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2 No 1 Yes or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Ther (Specific Pice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Yes 2 No Certification: To 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1. Natural 5 Pending s efter dea... raf Diractor: Aftr 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital c within 24 hours of To the Funaral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NEutaw St

32.

2006

Registrar's Signature

			For State Registrar	State of Ma	aryland	/ Depa	artment of F	lealth a		ntal Hy	giene	006	01342
	Physici	an	1. Decedent's Name (First, Middle,						2.	Date of Dea	Day	Year	3. Time of Death
	/Medic	al	Lovella 4a. Facility Name (If not institution,	Fullard			4b. City, Town, o	a Logotion of	f Dooth	01	14	2006 county of Death	2:21 PM
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	Funeral			6. Sex 7. Age	e (in yrs. ia.		If Under 1 Year	If Under 2		Date of Birt (Month, Da	h Vaar	N/A 9. Birthp	place (State or Foreign
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	and		Usual Residence of Decedent 10a. State 10b. County		10c, City.	Town or Lo	ocation					1	10d. Inside City Limits
	Maryl f sho	ក្ន	Maryland N/	А		ltimo							1 ☐ Yes 2 ☐ No
	r 28a	Directo	10e. Street and Number				10f. Zip Code					en of What Cour	
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	r dea	Funerail	11. Marital Status	12. Was Decedent Armed Forces?		. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Orig an, Mexican,	gin? (Specify	Yes or No- an, etc.)	- 14	Race - Americ Black, White,	
36	rs afte	by Fi	1 ☐ Never Married 2 ☐ Marrie 3 🖾 Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	No	1	1□ Yes X2□ No	Specify:				Specify: B	lack
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and	be fill ntal H ad ott	Be	17. Father's Name (First, Middle, La Abraham Roge						rs Name (Fi aret			'umame)	
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ē,	es 1 and of Health fitam 27 r othar t		20a. Method of Disposition		20b. Pla	ce of Dispo	osition (Name of matory or other place	ce)	Date		20c. Loca	ation - City or To	own, State
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Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service U	ceo ee		22	2. Name and Addre	ss of Facility	Chati	nan-E	Iarri	s Fun	eral Home
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			23a. Part . Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final	nly one cause on each lif	ne.		4				rest,		Approximate Interval Between Onset and Death
	Fnysician /Medical		disease or condition resulting in death)	a Enol	Sto	age	Renal	Dis	iease				
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687	8 E E	Physician/Medical		d									
Вох	eath certific attending pl	□/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7				23	d. Date of delive	эгу
	death	icia	in the past 12 months? 1 □ Yes 2 ☑No	1 ☐Live birth 4 ☐ Pregnant at 9 ☐ Unknown			□Ectopic pregnancy □ Other (specify)	/	·			Month	Day Year
P.0	at the de I by the a stached	Phys	9 🗆 Unknown								4		
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Ö	w requir been si should I	eted	Dementera						- 1				
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ta		a)	25. Was case referred to medical					26 Place	of Death (C		20 No	1 🗆 Yes	2♥No
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Division	or At after of Direction by	Certification:	4 Homicide determin		c. (Specily)	ne, farm, st	reet, factory, office		281.	City or Tox		Number of Hura	al Route Number,
	To the Hospital or Attend within 24 hours after death To tha Funeral Director: completely filled in by the		29a. Certifier 1 Certifying	Physician: To the best	of my know	ledge, deat	h occurred at the tir	ne, date and	d place, and	due to the	cause(s) a	nd manner as s	tated.
	n 24 h n 24 h na Fui	edicai	(Check only 2 ☐ Medical E	xaminer: On the basis of and manner sta	f examination	on and/or in	vestigation, in my o	pinion, deat	th occurred a	at the time,	date and p	lace, and due to	the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier	1+ ma	Lind	Paris	29c. Licens					signed (Month,	Day, Year)
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r	2		30. Name and address of person w	£ 11 1	eath (Item :	23a) (Type,	Dept of	medi	cine.	2%	South	Groen !	Street
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State of Maryland / Department of Health and Mental Hygiene

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artment of Health and Mental rtificate of Death	Reg. No.	U	U	D		3	l	J	-

			= State Registrar				Cei	rtificate	e of L	Death			Reg. No	o U	UU	UI	040
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	Funeral		5. Social Security Numb	er 6. Se	x	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Bi	rth		9. Birth	place (State ntry)	or Foreign
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	/land		10a. State 10t	b. County		10c. Ci	ty, Town or Lo	cation								10d. Inside C	City Limits
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P.O.	at the by the	hy	9 🗆 Unknown														
	as the	by	Part II. Other significar	nt conditions co	ntnbuting to	death but not re	sulting in the u	nderlying ca	ause give	en in Part I.		23e. Did	tobacco	use cont	ribute to	the cause of	death?
Division of Vital Records,	 requires that the death been signed by the ette should be detached for 	Completed by Physicia										1 🗆	Yes 2	2 25 100	3 Pro	bably 4 □]Unknown
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ita	ician: Th certificete rector, pag	Be	25. Was case referred examiner?	to medical						26. Place	of Death	(Check only					
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<u>.</u>	anding sath. or: After he fune	atic	2 Accident	investigation				М		Yes 2□	No						
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	withir To th comp	×	29b. Signature and tipe	of certifier		MA		290	. License	e number			29d. D	ate signe	d (Month	Day, Year)	
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	INX1		30. Name and address	of person who o	completed cau	use of death (Ite	m 23a) (Type,										
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Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

		For State Registrar	State of Mary	land / Depa		lealth and M	Mental Hygie		01344
Physici: /Medic	_	1. Decedent's Name (First, Middle, Las Vagn F. Flyger	t)				2. Date of Death Month January	Day Year	3. Time of Death 10:35 PM
Examin Funeral		4a. Facility Name (If not institution, give 109 Apple Grove 5. Social Security Number 6. Security Number 11	Road 7. Age (In	yrs. last birthday)	Silver	Spring If Under 24 Hrs. Hours Min.	8. Date of Birth	4c. County of Dea Montgome (ear) 9. Bir	TY thplace (State or Foreign ountry)
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death with the Maryland ms 23a or 28a-f show FITIUM Le notified at	ral Director	10e. Street and Number 109 Apple Grove I	Road		10f. Zip Code 209			USA	
ē 2 2	d by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 1		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Dican, etc.)	14. Race - Ame Black, Whi Specify: W	te, etc.
nd ZIZID-UU30 e filed within 72 hours af al Hygiene. other than "naturel", or vent, the Medical Exam	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or 5+) 5+	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of world)	king 16	b. Kind of Business	/Industry
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C, R t and Health mm 27 ther tr		19a. Informant's Name/Relationship (7) Beverly Flyger/s 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 ▼ Donation 5 □ Other (Specify	pouse Removal from State	109 Ob. Place of Dispo	Apple Gr	ove Road	Silver Sr Date 20	200	20904
DESILLING permit. Pages Department of I important: if Its eny injury or o		21. Signature of Funeral Service Licen Ronald S.	Wade, Dige	or St	Itimore.	omy Board	1 655 W. E		
Physician /Medical Examiner		23a. Part1. Inter the disease, or come shock. In heart failure. List only of the disease or condition resulting in death)	a. Due to (or as a col	STE	er the mode of dyir		or respiratory arres		Approximate Interval Between Onset and Death
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. 5 0 2	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
	by Р	Part II. Other significant conditions of		t resulting in the u		en in Part I.			o the cause of death? robably 4 □Unknown
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Jn Of Jing Phy: After this funeral d	ToB	examiner?	28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4 ☐ Nursing H	th (Check only one) ome 5 (A Resident 28d. Describe how		ocify)
To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral piece.	i Certification;	3 Suicide 4 Homicide 6 Could not be determined	building, etc. (S	pecify)			City or Town,		
To the Hosi within 24 ho To the Fund completely f	Medical	(Cneck only one) 29b. Signature and title of certifier	ysician: To the best of my niner: On the basis of exa and manner stated.	mination and/or in	vestigation, in my o	pinion, death occur	rred at the time, date	se(s) and manner as and place, and due	e to the cause(s)
F 3 F 8		30. Name and address of person who	completed cause of death	(Item 23a) (Type,			1		20774
Sta Registr		STEPHEW ST 31. Date filed (Mogth, Day, Year) JAN & 3 200	32. Registrar's S		MEZ	CAWTI	CE Ld) CARC	www.

		•	For State Registrar	State of Marylan		irtment of			iene 9. No. 200	6 0134
	Physici /Medic		Decedent's Name (First, Middle, Last) ADOLPH	J.	FRA	\M		2. Date of Deat		3. Time of Death 3:17 A м
	Examir Funeral Director		4a. Facility Name (If not institution, give s HOSPICE OF BALTIMO 5. Social Security Number 216-32-6554 Usual Residence of Decedent	RE GILCHRIST		4b. City, Town, If Under 1 Year Months Days		S. 8. Date of Birth		ALTIMORE Sinthplace (State or Foreign Country) MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23e or 28e-1 ehow ery injury or other traumatic event, the Medical Exercites trausities at another at	To Be Completed by Funeral Director	10a. State MD BALTIN 10e. Street and Number 9 POMONA SOUTH # 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade (Specify only highest grade) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) REUBEN 19a. Informant's Name/Relationship (Ty) RODNEY SCHLAFFM/ 20a. Method of Disposition 1 Daurial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	10RE 12. Was Decedent Ever in U Armed Forces? 1	S. 13. V. 16a. Decec (Give life. L. PROPR) FRAN 19b. Mailin 291 Place of Dispo emetery, cren ZUK AMU 22	ITMORE 10f. Zip Code Nas Decedent of Yes, specify Cult Yes, spec	pation e during most of we end) 18. Mother's Na CECEL at and Number or F OD CIRCLE ace) NGTON 1/2 ress of Facility STERSTOWI	Specify Yes or Norto Rican, etc.) orking ame (First, Middle,	Black, WI Specify: 16b. Kind of Busines MONUMENT Maiden Sumame) City or Town, State S PARK, P. 20c. Location - City BALTIM SON & BRO PIKESVILL	USA merican Indian, hite, etc. WHITE ss/Industry CO. SKLAR A 2/ip Code) A 19027 or Town, State ORE, MD S., INC. E, MD 21208
Box 68760,	that the death certificate be executed EX WA ed by the ettending physicien and detached for use as the burial-transit	sician/Medical Examiner	in the past 12 months? 1 \(\sumsetermin{a}\text{Yes} 2 \sumsetermin{a}\text{No}\)	Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq 1 Live birth 2 Feta	uence of): uence of): uence of):	hemi	no her	VIE	ASE	Approximate Interval Between Onset and Death O January Io January Io January Io January Joyana Year
Division of Vital Records, P.O.	To the Hospital or Attending Physicien: The law requires that the death certifich within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending I completely filled in by the funeral director, page 2 should be detached for use as	Medical Certification; To Be Completed by Physician/Me	9 Unknown Part II. Other significant conditions con Chrone Vent Regent Vent 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Phys	9□ Unknown tributing to death but not res (Aniluxe Fracture	ER/Outpatien 28b. Time of Injury UM/NOW Dome, farm, strr.	t 3 DOA Comment of the control of th	26. Place of Dether: 4 Nursing up at ork? Yes 2 A No	24a. Was an autops perform 1 yes 2 eath Check only on Home 5 Reside 28d. Describe ho 28f. Location (St. City or Town te, and due to the car curred at the time, da	24b. Were prior t death of the No. 1 You winjury occurred	Rural Route Number, Moths in S. H. m. as stated. ue to the cause(s)
) -	[D	ite	30. Name and address of person who of A Riley G British 31. Date filed (Month, Day, Year)		Charl		5200 Ballo.1	nd 248		19,2006
	Regist		1611 6 6 60		Es B	w/ -				

ORIGINAL

1/19/06 at

-05	21		i icusc i		epartment of Health and N	•		
			1 - For State Registrar	•	Certificate of Death	Reg. I	000-	0.1017
		П	Decedent's Name (First, Middle, Last)			2. Date of Death	U U	3. Time of Death
	Physici /Medio		FREDDIE GRAHA	M			² 21, 2006	1817 PM
	Examin	er	4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death		4c. County of Death	
	Euparal		MCDONOGH ROAD AND 5. Social Security Number 6. Sex		RANDALLSTOWN (day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	BALTIMORE 9. Birth	place (State or Foreign
	Funeral Director		241.86.5233 18	1M 2□F 56 Yr	Months Days Hours Min.	(Month Day Yes	ar Cou	place (State or Foreign ntry)
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	or Location			10d. Inside City Limits
	e Mary	ctor	MD BALTIMO	DRE WINDSO	OR MILL			1 ☐ Yes 20X No
	with the a or 28	Funeral Director	10e. Street and Number 1106 MANILA AV	VENUE	10f. Zip Code 21244	10g.	Citizen of What Cou	intry?
	me 23	nera			13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	
Maryland 21215-0036	nit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland artenent of Heelth and Mental Hyglene. ortant: if Item 27 ie merked other then "natural", or iteme 23e or 28e-f ehow injury or other treumatic event, the Madical Examinar must be notified at highly or ether treumatic event, the Madical Examinar must be notified at #8.	by	1 Never Married 2 Married 3 Widowed 4 ADvorced	Armed Forces? 1 ☐ Yes 2 (Mar)No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2/15 No Specify:	Rican, etc.)	Specify: BL	, etc. ACK
15-0	"natu	Completed	15. Decedent's Edu (Specify only highest grade	cation 16a. D	ecedent's Usual Occupation Give kind of work done during most of work fe. DO NOT use retired)	ing 16b.	. Kind of Business/Ir	ndustry
212	within liene. r then "	omp	Elementary/Secondary (0-12)	College (1-4or 5+)			ME IMPR	OVEMENT
Da.	be filed ital Hygi of other event, I	BeC	17. Father's Name (First, Middle, Last)	19/11		e (First, Middle, Maid		
yla	ould b Ment Marked	2	KOBERT GRAHAM		MARGAR			
	end 2 sh selth and n 27 le rr		19a. Informant's Name/Relationship (Ty, BETT) J. WINSTO	N 110		WINDSOR		
Baltimore,	Peges 1 nent of H int: if Iter iry or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R	cemetery.	crematory or other place)		Location - City or To	
iţi	permit. Peg Department Important: I eny injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furfaral Service License		PARK 01.28		NOAUSTON	
ă	Departr Imports eny inje		Dayson C		VAUGHN C GREENE DIST BALTO NATL PIK	HUNERAL S E. BAUTO.	ERVICE MD 212	29
and the same of th	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do no ne cause on each line.	enter the mode of dying, such as cardiac			Approximate Interval Between Onset and Death
	Examiner			Due to (or as a consequence of)	:			
	P #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Oue to (or as a consequence of)				
	siclen and burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a consequence of)	:			
1760,	2 > 0	cal	L.					
x 68	h certificat ending phy use as th	Med	IF FEMALE:	12- 14				
O. Box	the atte	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of deliv Month	ery Day Year
a	es that thighed by	by Ph	Part II. Other significant conditions cor	ntnbuting to death but not resulting in t	ne underlying cause given in Part I.	23e. Did tobacc	co use contribute to t	the cause of death?
ords	w require been sig should b	ted				1 🗆 Yes	200 No 3 □ Prol	bably 4 Unknown
of Vital Records,	0 00	Completed				24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
al		CO	25. Was case referred to medical			1/0 Yes 2□1		2□ No
<u>=</u>	Physicien: this cartific rai director,	0 8	examiner?	fospital:	Other	h <i>[Check only one)</i> ome 5 ☐ Residence	o ∯∏Other (Specific	SCENE
0		on: T	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury 28b. Tin	ne of 28c. Injury at	28d. Describe how in		
Division	ten leat for: the	cati	3 Suicide 6 Could not be	11011	M 1 Yes 20 No	Merina (Stran	rehauter	accillent
Div	i Die	Certification:	4 Homicide determined	2 6. Place of Injury - At home, farm building, etc. (Specify)	PCTT	28f. Location (Street Chy or Town, St.	ate)	al Houte Number,
)	Hospital 24 hours Funeral lately filled	edicai	29a. Certifier 1 Certifying Physical Check only 2 Medical Examinates	sician: To the best of my knowledge, oner: On the basis of examination and/ and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as s and place, and due t	stated. #133
ĺ	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. License number	29d. (Date signed (Month,	Day, Year)
	Λ		Chorher	W)	OCME	JAN	WARY 22,	2006
	X		30. Name and address of person who co	ompleted cause of death (Item 23a) (T	ype, Print) 111 PENN STREET	BAT.TTMOR	F MARVIA	ND 21201
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signature	Corde	, 2222121101	TENCHA	LID, 21201

			1 - For State Registrar	ate of Maryla		artment (and Men	ital Hygie	ene 006	01347
п	Physici	an	Decedent's Name (First, Middle, Last)	C 3 -			-		Date of Death Month	Day Year	3. Time of Death
	/Media	al	Delores Lorraine						anuary	14,200	
	Examir	er	4a. Facility Name (If not institution, give street FutureCare Homewo				wn, or Location o timore	of Death	9	4c. County of Dea	th
-	Funeral		Social Security Number	7. Age (In yrs	. last birthday)	If Under 1	rear If Under 2	24 Hrs. 8. [Date of Birth Month, Day, Y		thplace (State or Foreign
	Director		219-38-1647	₹ ₩ 63	Yrs.	Months D	Days Hours	Min. A	month, Day, Yo pril16	,1942 M	arvland
	ryland		10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
	Be-f	cto	Maryland N/A		Ba	ltimo	re				1 X Yes 2 □ No
	ath with ti 23a or 2 ust be n	Funeral Director	10e. Street and Number 3057 Spaulding A	venue		10f. Zip Co	21215		10g.	Citizen of Whaf Co. USA	ountry?
920	be filed within 72 hours after death with the Maryland at Hygiene. And Hygiene death of the Than "natural", or items 23a or 28e-f ehow event, the Madical Examiner must be notified at	by	1 Never Married 2 Married 1 If	as Decedent Ever in t med Forces?] Yes 2		Was Deceden If Yes, specify 1 ☐ Yes 25	t of Hispanic Orig Cuban, Mexican Mo Specify:	gin? (Specify i, Puerto Rica	Yes or No- n, etc.)	14. Race - Ame Black, Whit Specify: B	erican Indian, e, etc. lack
9	72 ho	ted	15. Decedent's Education	-/atad)	16a. Dece	dent's Usual C	occupation		16	b. Kind of Business	/Industry
21	within 7 ene. than "r he Med	Completed	(Specify only highest grade com Elementary/Secondary (0-12) Co	llege (1-4or 5+)	life.	DO NOT use i		t of working	-	1 C	la a m
7	Hygier Hygier Ither Ith		17. Father's Name (First, Middle, Last)	ears		Seam	stress			ailor S	
Maryland 21215-0036	should be find Mental Financed of	To Be	George Duppins,	Sr.				'	st, Middle, Mai or Pal		
, Mar	permit. Pages 1 and 2 should be Department of Heelih and Menta importent: if Item 27 is marked any injury or other traumatic en <u>once.</u>		19a Informant's Name/Relationship (Type, Pr Tanya S. Wright/		19b. Mailir 3057	ng Address (S Spau	treet and Number lding 2	ar or Rural Ro Ave.]	ute Number, C Baltin	ity or Town, State, A	Zip Code) 21215
Baltimore,	Pages 1 a ent of He nt: If item y or oth		20a. Method of Disposition 1 ☐ Burial 2 X(Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	armoni State	Place of Dispo			Date		c. Location - City or	Town, State
a E	mit. Partmoorter		21. Signature of Funeral Service Licensee	01			Address of Facility				neralHome
Ď.	Dep imp		Lory Va	ons				Chati			e.MD21215
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the dea se on each line.	th. Do not ent	er the mode o	f dying, such as o	cardiac or res	spirafory arrest,		Approximate Inferval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulfing in death)	Vhu	etasta	tic 4	ing a	urun	om4		Cumum Cumum
	/Medical Examiner		Tooling in doubly	Due to (or as a conse	quence of):						
	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):	-		_			
o,	icate be executed physician and s the burial-transit	Examiner	that initiated events	Due to (or as a conse	quence of):						
68760,	ficate by physical sthe bu	edicai	d								
P.O. Box	ires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transit	Physician/Med	in the past 12 months?	res, outcome of pregn □Live birth 2 □ Fet □Pregnant at time of a □ Unknown	al death 3	Ectopic pregr Other (speci				23d. Date of del Month	ivery Day Year
ls, P	The law requires that the te has been signed by the sage 2 should be detached.	Ď	Part II. Other significant conditions contributi	ng to death buf nof re	sulting in the u	nderlying caus	e given in Part I.				the cause of death?
Sorc	w require been si should b	eted							1 🗆 Yes		-2-3 A
Il Records,	: The lav cete has page 2 :	Completed							24a. Was an autopsy performed 1 ☐ Yes 2 ☑	prior to death?	topsy findings available completion of cause of 2 No
<u> </u>	Physicien: r this certifior ral director,	Be	25. Was case referred medical examiner?	ŀ		e - 11 - 1	Oth	of Leath Che			
ō	Phys rthis raldii	2	1 183 2-110	1 ☐ Inpatient 2 ☐ Date of Injury	ER/Outpatien 28b. Time of				5 Residence	e 6 □Other (Specialistics)	cify)
on	Attending r death. ector: After by the fune	tior	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	м 200.	Injury at Work? 1 Yes 2 N		Describe now	injury occurred	
É	2 g g c	Certification:	3 Suicide 6 Could not be	Place of Injury - At Inbuilding, etc. (Speci	nome, farm, str ify)	eet, factory, of	fice	28f. L	ocation (Stree City or Town, S	t and Number or Ru itate)	ral Route Number,
_	Hospital 14 hours e Funeral I tely filled	edical C	29a. Certifier Certifying Physician: (Check only one) Certifying Physician: Certifying Physician	To the best of my kn	owledge, death	occurred at t	he time, date and	d place, and d	fue to the caus	e(s) and manner as	stated.
	To the within 2 To the complet	Med	one) ar	d manner stated.			cense number				
)	8 48 4			10			-	6		Date signed (Monti	
14	\propto		30. Name and address of person who complete	edicause of deathy (Ite	m 23a) (Type,	Print)	0 1 1 0			111110	6 G1 71208
1	Sta	te	31. Date filed (Month, Day, Year)	32. Regisfrar's Sign	wa~ ature	()	538	916	ene	Tree	161 71208
	Registr	ar	JAN 2 3 2006 &	and to	Secretic.	1					

			1- For State of Maryla Registrar	-	artment of H		-	giene Rag. No. 2006	01348
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Frank L Greene				2. Date of Dea Month	Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of	Death	c. County of Dea	
			beness Perring Parkway Nursing	2 Facility	Park.	sille		Balt,	more
	Funeral		+67 M 2 T E	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Birt (Month, Da	th 9. Bir	thplace (State or Foreign
	Director		069-30-9572 ¹ ∑ ^{M 2□ F} 67	Yrs.	,,,		June 1	8, 1938 Was	
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. (City. Town or Lo	cation				10d. Inside City Limits
	Aaryti 1 sho	ō	MD Baltimore	Parkv					1 □Yes 2 No
	28a-	ect	10e. Street and Number	Idlkv	10f. Zip Code			10g. Citizen of What C	
	with Sa or	۵	1801 Wentworth Road			234		-	ountry :
	ns 2%	era	11. Marital Status 12. Was Decedent Ever in	U.S. 13.1			n? (Specify Yes or No	USA - 14. Race - Am	encan Indian.
(O	or Ital	Funeral Director	Armed Forces? 1 □ Never Married 2 □ Married 1 ☑ Yes 2 □ No	ľ			n? (Specify Yes or No- Puerto Rican, etc.)		
ဗ္ဗ	al', o	þ	3 X Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1☐Yes 2∏ No	Specify:		Specify: b	Lack
2	72 hc	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupa	ation	of working	16b. Kind of Business	/Industry
21215-0036	ithin De.	npi	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done of DO NOT use retired		, norming		
2	be filad within 72 hours after death with the Maryland tal Hygiene. id other than "natural", or Itams 23a or 28a-f show evant, if a Medical Erra" il actrinat ke trofiffied at	S	12 2	tra	ffic anal			city of Ne	w York
and	be fi	Be	17. Father's Name (First, Middle, Last)				s Name (First, Middle,	•	
چ	d Mer d Mer narks natic	2	Frank L. Greene Sr	401 11 77			mie Mae Ki		
Maryland	d 2 st h and 7 is n traun		19a. Informant's Name/Relationship (Type, Print)					er, City or Town, State,	Zip Code)
	permit. Pages 1 and 2 should be filad within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any injury or other traumatic evant, the Medical Exercitivet mat be notified at ance.		Carol Greene-Howard/sister 20a. Method of Disposition 20b	1521 D. Place of Dispo		Pkwy	Greensboro	NC 27407	Town State
Baltimore,	Pages nent of h ant: If its ary or of		1 Burial 2 Cremation 3 Removal from State	cemetery, cren	natory or other place	θ)		200. Coodilon Oily of	, own, otato
튶	artme ortani njury		'4 Donation 5 Mother (Specify) in state		. Name and Addres	s of Eacility			
Ba	Depa Impo any ir		21. Sign - a of Funeral Service Licensee Ronald S. Ware Wrece	o r Si	tate Anat altimore,	omy Bo	oard 655 W. 21201	Baltimore	Street
П			23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	ath. Do not ent-	er the mode of dying	g, such as ca	ardiac or respiratory ar	rest,	Approximate Interval Between
B	Pnysician		Immediate Cause (Final disease or condition	-una	Cancer	-			Onset and Death
п	/Medical		resulting in death) Due to (or as a conse	equence of					
	Examiner		Sequentially list conditions, b.						
	sit ad	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	equence of):					
_	and and I-tran	Examiner	that initiated events c. Due to (or as a const	equence of):					<u> </u>
8760,	icate be exacuted physician and s the burial-transit	dicai E							
687	ficate phys	adic	d						
Box	death certific e attending pl ed for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of preg					23d. Date of de	livery
	that the death cer ed by the attendin detached for use	cial	in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)			Month	Day Year
o.	t the cache	hys	9 ☐ Unknown						
S, D	s that ned t	by P	Part II. Other significant conditions contributing to death but not re	esulting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use contribute t	the cause of death?
rds	w requires t been signe should be	ed t					1 🗆 Y	fes 2□No 3□P	robably 4 Daknown
Vital Record		Completed					24a. Was		utopsy findings available
Ä	Physician: The laving this certificate has are director, page 2	E O					autop perfor		completion of cause of
ta	rtifica	Be C	25. Was case referred to medical			26. Place o	of Death (Check only o	7	
	Physician: this certific ral director,	ToE	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	☐ ER/Outpatien	t 3 DOA Cthe	Nurs	ing Home 5 Resid	dence 6 □Other (Spe	cify)
n of	ng Pt fter th neral	in C	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at c?	28d. Describe h	now injury occurred	
0	ttendii death. stor: A / the fu	catio	2 Accident investigation		M 1 🗆 1	Yes 2□No			
Division	l or Att after d Diract I in by	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined 28e. Place of Injury - At building, etc.)	home, farm, stre cify)	eet, factory, office		28f. Location (S City or Tow	Street and Number or R vn, State)	ural Route Number,
	pital ours a eral E		29a. Certifier 1 Certifying Physician: To the best of my k				alasa and divide the		
	To the Hospital or Attanding Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of examinand manner stated.	nation and/or inv	restigation, in my op	ie, date and pinion, death	occurred at the time,	cause(s) and manner as date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		29c. License	number		29d. Date signed (Mon	h, Day, Year)
			1 West		000	5943	23]	encary 10	2006
			30. Name and address of person who completed cause of death (It	ет 23а) (Туре,	Print)	0 00	-		
			Ndidi Feinberg Good Samer 31. Date filed (Month, Day, Year) 32. Registrar's Sig	Man Hos	bitm wat	Build	108 #303 1	Balt, more,	MD 215 39
	Sta Registi		JAN 2 3 2006	Hature And			,		
			Salt Marie Salt Salt Salt Salt Salt Salt Salt Salt	-					

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. weren't tems 1,205 per doc/fh g851 1-26-06 vt.
State of Maryland / Department of Health and Mental Hygiene 0 0 5 For State Registramend Item #18 Per FH G851 1/23/16 THE Registramend Item #18 Per FH G851 1/23/16 THE REGISTRATION OF THE REGI Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Frederick Garrison 3. Time of Death **Physician** ÖÏ ri Sor 21 2006 1105 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner resopeake Medical Centr Air Har tord f Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 212-20-866 83 Months Min Hours 0970571922 1**∑** M 2□ F Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow 27 is marked other than "naturel", or iteme 23e or 28e-f ebov treumatic event, the Medical Exeminer must be notified as Maryland Harford Street 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4530 Oak Ridge Drive 21132 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yès, Give Year or Dates: WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 文 No SpecifyWhite 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Installer C&P Telephone Co. 17. Father's Name (First, Middle, Last) ¹⁸ Cother's Name (First Middle, Maiden Sumame) Catherine Frances Frances Catherine Soper Be is marked or Pages 1 and 2 should be Frederick Garrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) to Health ? Daughter Barbara Grelli -2802 Willow View Court Hampstead, MD 21074 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 28 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Importent: If eny Injury or once. Parkwood Cemetery 01/27/2006 Parkville, Maryland 4 □ Donation _ 5 □ Other (Specify) 21. Signature of Funer Astroice Licente Charles F. Miner 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD Ilm 23a. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** ting lan /Medical Due to (or as a compuence of) Examiner annoteur Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dual to for as a consequence of Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Day 5 Other (specify) the detached 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, as been signal 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate 1 Yes 25 No 200 No 1 Yes or Attending Physician: funeral director 25. Was case referred to medical Be 26. Place of Death | Check only one examiner? Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient this 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 10 Natural 5 Pending within 24 hours after death. To the Funeret Director: A investigation 1 Yes 2 No 2 Accident the 6 Could not be determined 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) In by 1 pelli certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number DOG 63220 01/21/2006 MCMC SOS MPPER CHESAREALE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 171 SCUA RMS RGE BEL ASR, MD 2/014 GE0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6:20 AM Day Month **Physician** 16,200 Elijah G Goods Sanuary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Union Memorial Hospital Year If Under 24 Hrs. Days Hours Min. 7. Age (In yrs. last birthday) If Under 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Funeral Davs Months 1**√** M 2□ F Director 67 March9,1938 217-34-6357 Virginia Usual Residence of Decedent with the Maryland 10a, State 10c. City. Town or Location 10d. Inside City Limits 10b. County ral', or itema 23a or 28a-f show Exerciper mast be notified at 1 Yes 2 No Director N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2033 E. Jefferson St. 21205 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be tiled within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Iter any injury or other traumatic event, If a Medical Examinal ance. Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Efementary/Secondary (0-12) College (1-4or 5+) 9th Construction Worker Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Royster Goods Vergie Faulkner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grant E. Goods/son Leeds Creek Circle Odenton, Md 21113 20b. Pface of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State KingMemorialPark Jan. 25, 2006 Balto. Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO. MD 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1012/197 **Physician** rosu /Medical Due to (or as a consequence of): **Examiner** 94,15270 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical the *IF FEMALE* 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 🗌 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has I ral director, page 2 # a0topsy performed? 1 Yes 2 No 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 MInpatient 2 □ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 TYes 2 No 2 Accident investigation Funeral Director: tely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 24 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2006 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) HAL MEMORIAL HOSPITAL UNION 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Cooks. Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** FBECCA JUERSON 1006 QUI /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner Rock Glen Nursing Home
5. Social Security Number 6. Sex 7. Ag Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1□M 20F 104 Yrs. 220-30-7301 VA 01 10 1902 Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours aftar death with the Maryland Dapartmant of Haalth and Mentel Hyglena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination traugible at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County tX☐ Yes 2 ☐ No Funeral Director Baltimore NA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21216 U.S.A. 2200 Presbury Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic 6th grade na 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marry Owens Edward Owens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)

Physician /Medical Examiner 20a. I

EMENTIA

5 Pending

investigation

6 ☐ Could not be determined

25. Was case referred to medical examiner?

29b. Signature and title of certifie

1 ☐ Yes 2 ☐ No

27. Manger of Death

2 ☐ Accident

3 Suicide 4 Homicide

(Check only

31. Date filed (Month, D.

1 Natural

Examiner attanding physician end for usa as tha bunal-trensit cartificete be axecuted Physician/Medical signad by the attar þ Completed

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arai Director: Aftar this ce
ily filled in by the funeral dir To the Hospital of within 24 hours en To the Funaral Complately filled in the Total of the Total of the tensor of

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Certification: To

Medical

Division of Vital Records, P.O. Box 68760,

James C. Brock JrSon 20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State	
1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Cedar Hill	1/21/06 Glen Burnie, Md	
21. Signature of Funeral Service Licensee	22. Name and Address of Feci March F/H Wes 4300 Wabash	st Ave, Baltimore, Md 21215	
Immediate Cause (Final disease or condition resulting in death)	The death. Do not enter the mode of dying, such as the consequence of):	s cardiac of respiratory arrest, Intervel Between Onset end Death	_
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):		
Part II. Other significant conditions contributing to death be	ut not resulting in the underlying cause given in Part	23b. Did tobacco use contribute to the cause of death.	?

28c. Injury et Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the bests of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

BALTIMORE

1 ☐ Yes 2 ☐ No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) KENNET

NC,

2006

Suite 39

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an eutopsy performed?

1 Yes

28d. Describe how injury occurred

Other: 4 Tunursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

2 Lethu

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings evailable prior to completion of cause of death?

1 Yes 2LING

State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** Louise C. Kern 2:20p 19 January 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner TOWSON

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Months | Days | Hours | Min. | 1 2-19-1923 Baltimore Stella Maris 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 217-18-9718 82 Yrs. Baltimore, MD Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir then "natural", or iteme 23a or 28a-f show the Medical Examinar must be notified at MD 1⊠Yes 2 No n/a Baltimore Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Bouldin Street 210 S. 21224 deeth USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White ģ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) City of Baltimore Secretary 7 12th other t Maryland nent of Health and Mental Hy nt: if item 27 is marked othe 'y or other treament 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Domenic Tiburzi Marianna Rotondo 19a. Informant's Name/Relationship (Type, Print) SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Kern 2243 Old Washington Rd. Westminster, MD 21157 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State Sacred Heart Jesus 1/23/06 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. 21. Signature of Funeral Service Licenses oseph K 263 S. Conkling St. Baltimore, MD 21224 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Prebrovascular **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indicated events.) Due to (or as a consequence of). Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical phys IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No Month Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSpice Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending deeth. 1 □Yes 2 □No investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à within 24 hours after or To the Funered Direct completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 D idaney Valley Timonium MD 2093 MAHMOOD 1 ARTO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 18 2006 7:10 PM Wellington /Medical 4a. Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Catonsville Baltimore 2017 Rollingwood Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 € M 2 □ F 215-07-2670 86 Yrs Director Feb. 15, 1919 Maryland Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2017 Rollingwood Road 21228 USA "naturel', or items 23e Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "naturel", or iten any injury or other treumatic event, The Medical Examina. once. Black, White, etc. 1 Never Married 2 Married 1 ₹7 Yes 2 □ No Navy If ¥es, Give WWII Year or Dates: WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White 3 ☐ Widowed 4 ☐ Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Roofer Ruff Roofing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ada Galvin George Kuhn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Kuhn Wife 2017 Rollingwood Road; Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 □Donation 5 ▼Other (Specify)Entombment 1/21/2006 Loudon Park Cemetery Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature Funeral Service Lightness 1630 Edmondson Avenue; Catonsville, 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (Priysician disease or condition resulting in death) eno month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner The law requires that the death certificate be executed use as the burial-transit attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be Sementia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2 No Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 Yes 2 No 1 🔲 Inpatient 4 ☐ Nursing Home 5 ► Fesidence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier, 29d. Date signed (Month, Day, Year) 4005433 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard 3250 Storting bute Ut Woodbine and 21797 DO Lanacci 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 3 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Year Month **Physician** Joseph January 19, 2006 Α. Kachmarsky 11:30a /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Charlestown Nursing Facility Catonsville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 1, 1915 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** New Jersey 1 № 2 □ F 90 151-10-2775 Director Usual Residence of Decedent with the Maryland 10d. fnside City Limits 10c. City, Town or Location 10a. State 10b. County ral, or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 □ No Director Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 709 Maiden Choice Lane 21228 deeth Funeral 12. Was Decedent Ever in U.S. Ammed Forces? 1∑ Yes 2 □ No 1943 – If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married 10 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: Specify: ģ 3 ₩ Widowed 4 Divorced Completed 7 is marked other than "natur traumatic event, I've Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Fire Department Captain City of Bayonne, NJ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Kascik Steven Kachmarsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12761 Folly Quarter Road Ellicott City, MD 21042 Janice Cox/Daughter other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 01/24/2006 Holy Cross Cemetery North Arlington, NJ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
O'Brien Funeral Home 21. Signature of Funeral Service Licensee 984 Avenue C Bayonne, NJ 07002 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Finaf 0 Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause to see the cause to be seen to b Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician by Physician/Medical as the l IF FEMALE: 980 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. page 2 should be detached 9☐ Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 1 Yes 2 No 3 Probably Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? or Attending Division Natural 2 Accident 5 Pending after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after lilled Hospital within 24 hours To the Funeral OM Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of 2016 30 Name and address of person who completed cause of death (ftem 23a) (Type, Print) (ang (971 Maide 1016 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

ORIGINAL

			1 - For State Registrar	State of Ma	ırylanı		artmen			and M		jiene	006	01355
4	#	м	1. Decedent's Name (First, Middle, I	ast)							2. Date of Dea			3. Time of Death
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	/Medio		4a. Facility Name (If not institution, g						Location o	of Death	Danualy		ounty of Dea	0.02 F
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3	Funeral			Sex 7. Age	(In yrs. la	ast birthday)	If Under Months	1 Year	If Under 2		8. Date of Birth (Month, Day		9. Bir	thplace (State or Foreign
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	and w		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	eation							
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,	289-	Director	10e. Street and Number				10f. Zip	Codo				0- 0:::		
	3a or		108 Walnut Aven									og. Cilize	en of What Co	
į	ле 2; гле 2;	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S	S. 13. V		L206	nanic Orig	nin? (Sne	activ Yes or No-	14	Race - Ame	S.A.
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	be lied with 72 nouts after death with the Maryland lat Hygiene. Ital Hygiene. Id other then "netural", or iteme 23a or 28a-f ehow event, the Medical Examinar must be notified at	Completed	15. Decedent's (Specify only highest of	Education		16a. Deced	dent's Usua	I Occupat	tion	at unde		16b. Kind	of Business	Industry
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7	and Men	2	Gordon		McC	umber			Edit					Froves
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υ,	Health em 27 ther tr		Connie L. Cox (20a. Method of Disposition	Daughter)	20b PI:	ace of Dispo:			nue C		lea, Mar			
2	rages nent of int: int: if it		1 Durial 2 ☐ Cremation 3	Removal from State	СӨ	metery, crem	natory or of	her place) J	Janua	ary 25,	zuc. Loca	ition - City or	Town, State
			4 ☐Donation 5 ☐ Other (Special Signature of Funeral Service Lice	**	0ak	Lawn	Cemet	ery	of Facility		2006 E	ast	Point,	Maryland
	Depertment Depertment imports eny inju		· Malall		- 15	/ W	. Dab	rows	ki/Ch	nojna	acki Fun			
			23a. Part1. Enter the disease, or co	mplications that caused to	he death.	Do not ente	005 D	unda	1k Av	e. I	Baltimor	e, M	arylan	d 21224 Approximate
D	bysisian		Immediate Cause (Final	y one cause on each line). -				A		r toopingtory and	, ,		Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	a. Due to (or as a		come of		100	hm	R				
E	xaminer			De)-0 0-	tia								
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o o o o o o o o o o o o o o o o o o o	sicien end burial-transit		resulting in death) Last	Due to (or as a		ence of):	,							
	the	dicai	•	_d	4120	Thyn	Dide	22						
\ i	ettending p	Physician/Me	IF FEMALE:	23c. If yes, outcome of	l prognan									
	etten for u	clan	23b. Was decedent pregnant in the past 12 months?	1□Live birth 2 4□Pregnant at ti	☐ Fetal d	death 3 🗌	Ectopic pre					230	 Date of delification Month 	very Day Year
) 2	ed by the detached	iysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	ille oi des	a(() 5 L	Other (spe	ciry)						
The law requires that the death certific	ned b	by Pi	Part II. Other significant conditions	contributing to death but	not result	ting in the un	derlying ca	use given	in Part I.	_	23e. Did tob	acco use	contribute to	the cause of death?
3	n sign uld be										1 ☐ Ye	s 2 🗆 N	No 3∐Pro	bably 4 Bunknown
3	as been si	Set									24a. Was ar		24h Woro au	topsy findings available
1	page	Completed								_	autopsy perform	ed?	prior to c death?	ompletion of cause of
		0	25. Was case referred to medical						26 Place o	of Death	(Check only one		1 ∐ Yes	2□ No
veic	S . D	ToB	examiner?	Hospital:	2 □ E	R/Outpatient	3 DO	0.0			ne 5 ☐ Reside		Other (Snec	(h)
Attending Physician:	fter th		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day)	Year) 2	28b. Time of Injury	28	lc. Injury a Work?			8d. Describe ho			(1)
ipoe	eath. or: A the fu	cati	2 ☐ Accident investigate	on			М		s 2 No	0				
or A	fter d Direct n by	Certification:	3 Suicide 6 Could not 4 Homicide determined		y - At horr (Specify)	ne, farm, stre	et, factory,	office		2	8f. Location (Str. City or Town,	eet and N State)	lumber or Rui	ral Route Number,
Hospitai	oral C	- F	00-0-0											
HOS	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of each manner state	xamınatıc	ledge, death on and/or inve	occurred a estigation, i	t the time, in my opin	date and lion, death	place, a occurre	nd due to the ca d at the time, da	use(s) and te and pla	d manner as	stated. to the cause(s)
othe	o th	Me	29b. Signature and title of certifier	und maintor state				License r					igned (Month	
	7.20		· Don	tal	M	1)			146	4			23	
	/		30. Name and address of person who				Print)						1	
	9		SHOA113 A HASITA					mile	304	P, I	ALTIM	ORE	mp	21201
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's			_							
	Registra	ar -	JAN 2 3	2006	18 0	K	La. N							

		For State	State of Maryland	d / Depa	artment of H	lealth and I	•	•	16 0135
		Registrar		Cei	rtificate of	Death		g. No.	0100
Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Ye	3. Time of Death
/Medic		Ruth L. Montley							
Examin		4a. Fecility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Death	1	4c. County of [Death
		Mariner North Aru	ınde1		Glen Bu	ırnie		Anne A	rundel
Funeral		5. Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Forei Country)
Director		219-32-5092	M 2 ▼ 69	Yrs.			Feb 1, 1		aryland
122411		Usual Residence of Decedent	140-05	T					Trail II ab III
Vo III	_	10a. State 10b. County		y, Town or Lo					10d. Inside City Limi
- 9	cto	MD Anne Aru	ıdeT l	Pasade	na				1 □ Yes 2√2 N
or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	t Country?
238	aic	917 Beals Trail			21122	2		USA	A
# E	Funeral	11. Marital Status	2. Was Decedent Ever in U.: Armed Forces?	S. 13.	Was Decedent of H	dispanic Origin? (Si an, Mexican, Puert	pecify Yes or No-	14. Race - /	American Indian,
ital Hygiene. id other than "natural", or items 23a or 28a-f show svent, i'te Medical Examinar cust be notified at	F	1 ☐ Never Married 2 X Married	1 ☐ Yes 2 No				Tricari, etc.)		Vhite, etc.
E	by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 ☐ Yes 2 🎇 No	Specify:		Specify:	white
cal	ted	15. Decedent's Educ (Specify only highest grade	ation		dent's Usual Occup	oation during most of wor	tina 1	6b. Kind of Busin	ess/Industry
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Hygiene. ther the	Completed	12	0	shor	t order	cook		restara	unts
oth int,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, M	laiden Sumame)	
ked c s	To B	Charles Dola Hoy				Margare	t Janet	Bell	
I Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic svent, the Mactical Examinar must be notified at	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Street		ral Route Number,		te, Zip Code)
th a		George Montley/sp	01100				ena, MD 2		
item 27 other tr		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of			Oc. Location - City	or Town, State
nent of l		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	emetery, cre	matory or other plac	ce)			
tmer tant jury		* 4 Donation 5 ☐ Other (Specify)	1			l			
Department of Important: If i any injury or once.		21. Signature of Funeral Service License Ronald S. V	Mence	1.00	arcimore.	TID ZIZY	d 655 W.		e Street
nysician Medical		23a. Pen1. Enter the disease, or combis shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	atrial	n. Do not ent	ter the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
ate has been signed by the attending physicien and Brage 2 should be detached for use as the burial-transit on	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ		uia)				
ittending por use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 2 in the past 12 months?	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal	I death 3	Ectopic pregnancy	у		23d. Date of	delivery Day Year
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tifica tor. p	a	25. Was case referred to medical				26 Place of Dea	th (Check only one		
s certificate has b director, page 2 s	0 8	evaminer?	lospital: 1 Inpatient 2	ER/Outpation	nt 3 DOA Oth	200	ome 5 Resider		Space(64)
eath. tor: After this certificate ha the funeral director, page	H	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. Injur	ry at	28d. Describe how		opacity)
h. After funer	Certification:	1 Accident 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wor	rk? Yes 2 □No			
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Dire in by	artii	4 Homicide determined	building, etc. (Specify	y)			City or Town,	State)	
within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical Ce	(Check only 2 Madical Exami)	sician: To the best of my kno ner: On the basis of examinal	wiedge, deat	h occurred at the til	me, date and place	, and due to the car	use(s) and manne	or as stated.
the I	led	one)	and manner stated.						
To	Σ	29b. Signature and title of certifier			29c. Licens			d. Date signed (N	
		(Aumenotic	and us		1)54	to20	1	IMILAL	16 200 All not
		30. Name and address of person who co	mpleted cause of death (Item	п 23а) (Туре,	Print)		V	/	1
		Chimene	Liburd M.	0 2	401 Bro	andermil	Blue #	330 Gan	souls wis 2
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	6.0° -			, /	
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			For State Registrar	State of Ma	iryiand				Death	ia iviei		g. No.	UUD	01337
	Physicia	an	Decedent's Name (First, Middle, Last,								Date of Death Month	Day	Year	3. Time of Death
	/Medic	_	Fern	L				tens			anuary	T		6:40 PM ^M
•	Examin	er	4a. Facility Name (If not institution, give				,		r Location of I	Death			County of Dea	
	Francis I		Arden Court Nursing 5. Social Security Number 6. Sec		(In yrs. las	t birthday)	If Unde		If Under 24	Hrs. 8.	Date of Birth (Month, Day,		ontgome 9. Bir	ery thplace (State or Foreign ountry)
	Funeral Director		333-05-6073]M 2፟∭ F	88	Yrs.	Months	Days	Hours	Min.	(Month, Day, ept. 7	Year) 19	17 11	linois
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Loca	ation							10d. Inside City Limits
	a-f eh	ctor	Maryland Montgo	mery	Kens	ingto	n							1 ☐ Yes 2 🔀 No
	or 28	Directo	10e. Street and Number				10f. Zi	p Code			10	og. Citiz	zen of What Co	ountry?
	ath w	la	4301 Knowles Aven					895					S.A.	
	er de	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		13. W	as Dece Yes, spe	edent of H ecify Cuba	fispanic Origir an, Mexican, F	n? (Specif Puerto Ric	y Yes or No- an, etc.)	'	 Race - Ame Black, White 	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 N If Yes, Give Year or Dates:	10	1 (☐ Yes	2 ™ №	Specify:				Specify: Wh	nite
ž	2 hou		15. Decedent's Edu			16a. Decede	ent's Usu	ial Occup	ation during most o	f working		16b. Kir	nd of Business	/Industry
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or iteme 23a or 28a-f ehow ent, I'la Mudical Exame ar must be notified a	Completed	(Specify only highest grad	College (1-4or 5		life. Do	O NOT	use retired	d)	ii working		•		
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anc	ould be filed v Mental Hygie varked other i	o Be	Earl Rehfeld						Lotti			iaidon (ourname)	
2	should ind Men marke umatic	2	19a. Informant's Name/Relationship (T)	rpe, Print)		19b. Mailing	Addres	s (Street				City or	Town, State,	Zip Code)
	1 and 2 Health a tem 27 is		Lee Mortenson	(Son)	1	2033	Trai	llrid	lge Dr	., P	otomac,	MD	20854	
ore.	of He of He f Item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	Removal from State	20b. Plac	e of Disposi letery, crema	ition (Na atory or	ime of other plac	ce)	Date	9 2	20c. Loc	cation - City or	Town, State
Ĕ	Pages ment of tent: If It lury or o		4 ☐ Donation 5 ☐ Other (Specify)		Acad				ery 1		_	Chic	ago, I	L
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment: if them 27 is marked other than "natural", or Iteme 23s or 28s-f show any injury or other traumatic event, if a Mardical Exam car must be notified at once.		21. Signature Funeral Service Licens	hour					ineral Cicero			ago,	IL 60	641
	***		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused ne cause on each lir	the death. ie.	Do not enter	r the mo	de of dyir	ng, such as ca	ardiac or re	espiratory arre	st,		Approximate Interval Between
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_	certifi ding l		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnanc	y						2	3d. Date of de	livery
P.O. Box	death e atter	by Physician/N	in the past 12-months? 1 □ Yes 2 ☑ No	1 Live birth 4 Pregnant at			Ectopic p Other (s	regnancy pecify) _	у				Month	Day Year
0	at the by the tache	hys	9 Unknown	9□ Unknown				_		_				
S,	Attending Physicien: The law requires that the death certificate be executed rideath. sector: After this certificate has been signed by the attending physician and better. After this certificate as the burial-transit by the funeral director, page 2 should be detached for use as the burial-transit.		Part II. Other significant conditions co	ntributing to death b	ut not resulti	ng in the und	derlying	cause giv	en in Part I.		23e. Did tob	N.	1	the cause of death?
Š	v requ been shouk	Completed								- 12	24a. Was ar	_/	Y	utoney findings available
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ta	an: T tificet tor. p	0	25. Was case referred to medical						26. Place o	of Death (C	1 ☐ Yes 2 Check only one		1 1 105	3 2 □ No
<u> </u>	ysici	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🗌 Inpatie	nt 2 EF	VOutpatient	3 🗆 D	OA Ott	ner: 4 📉 Nurs	ing Home	5 Reside	nce 6	3 □Other (Spe	icity)
0	ng Ph fter th neral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Day	y Year) 2	8b. Time of Injury		28c. Injur Wor	rk?		d. Describe ho	w injury	occurred /	
Sio	tendii leath. tor: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2 □ No		(0)			
Division of Vital Records,	al or Att	Certification:	4 Homicide determined	28e. Place of Injubulding, etc.	ury - At hom c. (Specify)	e, farm, stre	et, facto	ry, office		281	City or Town			ural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best inar: On the basis of and manner sta	examination	edge, death n and/or inve	occurre	d at the tir n, in my o	me, date and opinion, death	place, and occurred	d due to the ca at the time, da	use(s) ate and	and manner as place, and due	s stated. e to the cause(s)
	ro the	Me	29b. Signature and title of certifier	•			29	c. Licens	se number		25	9d. Date	e signed (Mont	th, Day, Year)
	- Li		> Alparely	man	Mil).		0-	2760	60		1	117/0	6
1	, 0		30. Name and address of person who co									-		
U	Z		Alpana Goswami,				i116	e Pik	ke, Roc	kvil	le, Mai	ry1a	ınd	
1	Sta	ate	31. Date filed (Month, Day, Year)	76 Registra	ar's Signatur	He Ann	200)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State	State of Marylar		artment of H		nd Mental H		211116	01358
	9		Registrar 1. Decedent's Name (First, Middle, Las	r)	061	incate of L	Jeani	2. Date of D	Reg. Ne	σ. Ο Ο Ο	3. Time of Death
	Physici /Medic		Joe :	S PATTE	RS			Jan	20		6 2206 PM
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or			40	c. County of Dea	
			5. Social Security Number 6. Se			If Under 1 Year	If Under 2	111		Howa	
	Funeral Director			X 7. Age (In yrs.	Yrs.	Months Days	Hours	Min. 8. Date of E (Month, L	IQ 3U	9. Bir	thplace (State or Foreign ountry)
	D		Usual Residence of Decedent					10.12.	17 04	2	
	show	7	10a. State 10b. County		ty, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 M No
	28e-f	rect	MD HOWARI 10e. Street and Number	, (0)	UMBIA	10f. Zip Code			100 C	itizen of What C	
	h with	Funeral Director	5288 CORNCOCKU	E COURT		21045	;		109.0	IIQΔ	outhry.
	ems sermi	ıner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	1	spanic Origi	n? (Specify Yes or N	10-	14. Race - Am Black, Whi	
20	hours after death with the Maryland tural', or Items 23a or 28e-f show at Examiner must be notified at	by F.	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 ☐ No If Yes, Give	i	1 ☐ Yes 2 🔀 No	Specify:				
5-003p	should be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other than "natural", or flems 23a or 28e-f show marked other than "natural", or flems 23a or 28e-f show matic event, the Medical Examiner must be notified at		15. Decedent's Ed	Year or Dates:	16a. Dece	dent's Usual Occupa	ation	-	16b. l	Kind of Business	ACK Vindustry
2 2	thin 73 e. en "na Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	life.	kind of work done of DO NOT use retired,	during most (of working			
7	filed within 72 Hygiene. other than "na ant, the Medic	Con	12 TH GRADE	8 YRS	Aui	DITOR			1 000		GOVT.
and	ould be fil Mental H arked ott atic even	Be	17. Father's Name (First, Middle, Last)	UNK.			18. Mother'	s Name (First, Midd		n Sumame)	
Maryland	s 1 and 2 should if Health and Men If Health and Men Item 27 is marke other traumatic	70	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailie			or Rural Route Num		or Town, State.	Zin Code)
	tand 2 s Health ar Iem 27 ls		PEARLENA PATTE	RS (WIFE)	1	CORNCOCK		CT., COLU			2045
altimore,	es 1 a of Hea of Item f Item		20a. Method of Disposition 1 Surial 2 Cremation 3	20b. I	Place of Dispo	sition (Name of natory or other place		Date		ocation - City or	Town, State
Ě	Pages Iment of tant; If It tant or o		*4 □Donation 5 □ Other (Specify) <u>M</u> 1		10NAL	0	1.28.06	LAU	IREL N	MD
ga	permit. Pages Department of Important: If II any injury or c		21. Signature of Fulleral Service Licen	71 /	VA	Name and Addres	s of Facility	FUNERAL	SER	VICE	
			23a. Part1. Enterine disease, or comp	lications that caused the deal	2	D) RHMO I	MAIL P	IKE RHUL). IV][0 21229	Approximate
	Physician		shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.			,				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. HYPOXIA Due to (or as a consec	quence of):	-					
	Examiner		Sequentially list conditions,	b. Ventrian		billation	1				
	ed isi	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec		A.					
	xecut and al-tran	Examiner	that initiated events resulting in death) Last	c. Carolio n Due to (or as a consec		Huy					
8/60	icate be executed physician and s the burial-transit	dicai i		d							
9	ing ph	Medi	IF FEMALE:			-					
Box	death certific e attending p d for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta	aldeath 3[Ectopic pregnancy				23d. Date of de Month	livery Day Year
o.	0 0	ysic	1 Yes 2 No	4□Pregnant at time of o 9□ Unknown	death 51	Other (specify)					,
<u>.</u>	The law requires that the tte has been signed by the bage 2 should be detache	by Ph	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Dic	Itobacco	use contribute to	o the cause of death?
202	w requires been sign should be							19	Yes 2	2 □ No 3 □ P	robably 4 Unknown
Records,	law re as bee 2 sho	Completed						24a. Wa	s an opsy	24b. Were a	utopsy findings available completion of cause of
		Com						per 1 ☐ Yes	formed?	death?	s 2□No
Viita	ding Physicien: Th n. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	,	Othe		of Death (Check only	one)	78.30=32	
	Phys r this ral dir	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time o		4 INUIS	sing Home 5 Re.			ecify)
0	nding th. :: Afte e fune	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Work	k? Yes 2 ∐ No			.,	
Division of	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str	eet, factory, office			(Street a		ural Route Number,
ā	ital or irs afti ral Di							- 10			
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 Certifying Phyone (Check only one) 2 Medical Example 1	ysician: To the best of my kno iner: On the basis of examina	owledge, deat ation and/or in	n occurred at the tim vestigation, in my op	e, date and pinion, death	place, and due to the occurred at the time	e cause(s e, date an	s) and manner as od place, and due	s stated. e to the cause(s)
	o the	Mec	29b. Signature and title of certifier	and manner stated.		29c. License				ate signed (Moni	
	- s + ō		> GASUNGERS	2 ms		Don	5717	7	Jo	an 21	, 2006
	15			completed cause of death (Iter	п 23а) (Туре,	Print)	0	bie MS	-	-	, 2-06
	15		E.A. ENG			r Ln C	dum	suc MS	21	044	
: 4,	Sta Regist		31. Date filed (Month, Day, Year) JAN 2 3	32. Registrar's Sign	a a	hoods.					
	- riegisti		טחוז ט	LUUU JANGARA	20 10						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** JANUARY PROHOVNIK 18 2006 6:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MILFORD MANOR NURSING HOME BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month Day, Year FEB. 18, 1916 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 € M 2 □ F Days Hours 89 Yrs. Director 347-05-0222 IL Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location in than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🗓 No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 7610 LABYRINTH ROAD 21208 **USA** death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int; if Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN CLOTHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ARRAHAM PROHOVNIK SARAH ပ ICKOWITZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important; If Item 27 is any injury or other trau QDCE. 7610 LABYRINTH ROAD - BALTIMORE, MD 21208 FAYE PROHOVNIK / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CHIZUK AMUNO ARLINGTON 1/20/2006 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Security Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** UNTEV Thec /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ut as a consequence of): Examine or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Tyes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 2 No 1 ☐ Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at/ Work? Certification: 28d. Describe how injury occurred After s after deau. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and state and the to the coursels) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) completed cause of death (tem 23a) (Typi Srint) 31. Date filed (Month, Day, Year) \$2. Registrar's Signature State JAN 2 3 2006 Registrar

1			For State Registrar				nd / Dep		t of H	ealth a	and N	Mental Hyg		2006	William State	360
	· 1803 - 18	堻	Decedent's Name (First, Michael Control of the	idle, Last	·)							2. Date of Dea			3. Time	of Death
	Physici /Medi Examir	cal	Antionette M 4a. Facility Name (If not institut			m <i>ber)</i>		4b. City,	Town, or	Location o	of Death	Month January				5 PM
14	LAGIIII		St. Thomas M				r	Hyat	ttsv:	ille			Pr	ince Ge	orge	;
	Funeral		5. Social Security Number	6. Se	x		s. last birthday)		1 Year	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day)		7	hplace (State	
	Director		577-50-0059 Usuaf Residence of Decedent	11	_M 2√ F	70	Yrs.					Sept 13	, 19	935 Wash	ningto	n DC
	irylan show		10a. State 10b. Cour	nty		10c. C	City, Town or L	ocation							10d. Inside	_
	the Marylar 28a-f show notified at	cto		ice G	George'	s	Hyattsv	ille							1 [] Ye	s 2 No
	72 hours after death with the Maryland 'natural', or Itema 23a or 28a-f show dical Evantrat must be notitled at	by Funeral Director	10e. Street and Number	D 1				10f. Zip	Code	2070		1	0g. Cit	zen of What Co	untry?	
	8 23s	rai	4922 LaSalle	Koad			11.0			2078		7 17		USA		
	ltem Ferr	nue	11. Marital Status 1 ☐ Never Married 2 ☐ M	0.000.00	Armed Fo		U.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cuba	ispanic Ori n, Mexican	gin? (Sp 1, Puerto	ecify Yes or No- Rican, etc.)		 Race - Ame Bleck, White 		
36	Ir, or	by	3 Widowed 4 Divorc		ff Yes, Gr	ve		1 ☐ Yes	2₹ No	Specify:				Specify: wh	ite	
21215-0036	2 hou	ed	15. Deced	ent's Edu	ucation		16a. Dece	dent's Usua	al Occupa	ation			16b. Ki	nd of Business/	Industry	unk
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pu	al Hy al Hy 1 oth	Be (17. Father's Name (First, Middle	le, Last)								e (First, Middle, I				
yla	Ment Ment arked	0	John Stanley	Go1	ab					Ros	e El	eanor U	bar	l		
Maryland	2 short		19a. Informant's Name/Relation	nship (T)	ype, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rur	al Route Number	City o	r Town, State, 2	(ip Code)	
	and lealth m 27 har ti		Michael Rice/	son		205				nue C	-	on, TX 79				
altimore	ges 1 if of H if Ite or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematio	n 3 □F	Removal from		Place of Dispe cemetery, cre	matory or o	ther plac	8)		Date	20c. Lc	cation - City or	Town, State	
ţim	t. Pa ntmen rtant:		4 ∑Donation 5 ☐ Other							1						
Sa	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If Item 27 Is marked other then "natural", or Items 23s or 28s-1 show amy injury or other traumatic event, the Medical Examinar must be notified at Once.		21. Signature of Funeral Serv	S V	wade, I	Viteore		state saltim			Boar 212	d 655 W. Ul	Ва	ltimore	Stree	t
			2 a. Part1. Enter the disease, shock, or heart failure. L	or complist only o	lica ions that one cause on o	caused the dea	ath. Do not en	ter the mod	e of dying	g, such as	cardiac	or respiratory arri	est,	1880	Approxima Interval Be	ate etween
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760,	be executed iician and burial-transit	caiE			D06 (0	(or as a conse	querice (ii).									
687	physis the			•	d											
×	certif nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	2	23c. If yes, ou	tcome of pregi	nancy							23d. Date of deli	V95/	
Вох	atter for u	ciar	in the past 12 months?		1 Live t	oirth 2 Fe nant at time of	tal death 3	□Ectopic pro □ Other (sp						Month	Day	Year
o.	the d	ysi	9 Unknown		9□ Unkn				<i>//</i> —							
0	The law requires that the death certificate be executed ate bas been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Physician/Med	Part II. Other significant cond	itions co	ntributing to d	eath but not re	sulting in the u	ndertying ca	ause give	en in Part I.		23e. Did tot	acco u	se contribute to	the cause of	death?
rds	quire on sig uld b	pa p	Kenal ta	<u>III</u>	re							1 🗆 Ye	s 2[□No 3□Pro	obably 4]Unknown
Records,	aw requir s been si 2 should	plet	Chronic=	073	Druc	rtî ve	III	nac	dīz	lea	مد	24a. Wasa		24b. Were au	topsy finding	s available
R	ding Physician: The lav h. After this certificate has funeral director, page 23	E O						1				autops perform	ned?	death?	ompletion of	cause of
Vital	ian: rtrifica stor, p	Bec	25. Was case referred to medi	cal				100		26. Place	of Deat	h Check only on	A	7 🗆 100	20110	
<u></u>	Physician: this certific ral director,	P P	examiner? 1 ☐ Yes 2 No	ŀ	Hospital: 1 🗆	Inpatient 2	ER/Outpatie	nt 3 🗆 DO	A Othe	91: 4 Nu	rsing Ho	me 5 Reside	nce (3 □Other (Spec	city)	
n of	ng Pl	:: U	27. Manner of Death 1 Natural 5 ☐ Pen	dina	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury	of 2	8c. Injury Work	at /		28d. Describe ho	w injur	y occurred		
Sio	Attending r death. sctor: After by the fune	cati	2 Accident inve	stigation id not be				М		Yes 2 🗆 I	No					
Division	or Ati	Certification;		imined	28e. Place build	of Injury - At ing, etc. <i>(Spe</i> c	home, farm, st cify)	reet, factory	, office			28f. Location (St. City or Town			ral Route Nu	mber,
	pltal	2	29a, Certifier 1X Certif	vina Phy	rsician: To the	a hast of my kr	TOWINGE COST	h oncurred	at the time	o data an	d olean	and due to the ca				-
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medic	al Exami	iner: On the b	asis of examir ner stated.	nation and/or in	vestigation,	in my op	pinion, deal	d place, th occuri	red at the time, da	iuse(s) ate and	and manner as place, and due	stated. to the cause	(s)
	To th withir To th comp	Me	29b. Signature and title of certi	tjer)				290	. License	number		2	9d. Dat	e signed (Monti	, Day, Year)	~-
)			* * 7	Ch	Q,	,		7	210	1674	7		1-	-11-0	6	
			30. Name and addres >>> person	on who c	omplet o vau	se of death (Ite	em 23a) (Type,	Print)	-	Ran	ra	n.R. 11	Ui			
			3503 Ke	vry	Styl	eet	MT.	Kai	nce	1.1	AD	207	12			
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	Regist	ar	Oniv	O L	100 Just		De State	A STATE OF THE PARTY OF THE PAR								

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** January 16, Thomas Latney Reynolds 2006 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan. 28 Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F Director 68 Yrs Jan. 1937 Virginia 231-44-4639 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "natural", or itema 23a or 28a-f ehow Director 1 XYes 2 No D.C. None Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5622 9th Street N.W. 20011 U.S.A. within 72 hours efter deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Heating Engineer D.C. Public Schools permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked oth any lojury or other traumatic event, otics. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Ashby Reynolds, Sr ပ Thelma Elouise Grant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5622 9th Street NW Washington, DC (Wife) 20011 Annie Lillian Reynolds 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Antioch Baptist Church 1/21/06 Champlain, VA 21. Signature V Funeral Service Licenses 22. Name and Address of Facility Washington Funeral Home Milmen ennes P.O. Box 476 Tappahanock, VA 22560 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Metastatic Colon Cancer /Medical Due to (or as a consequence of): Examiner Right Lung Abcess Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, by Physician/Medical use as the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate hes page 2 s autopsy performed? Yes 2.2.No certificate 1 ☐ Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: ို 1 ☐ Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: Al completely filled in by the fu deeth. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) V0056063 6 eted cause of death (Item 23a) (Type, Print) M.D. 1500 Forest Glen Rd., Silver Spring, MD 20910 Nagi Kanwaljit, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	ertificate of			giene ()	06	01362
	Physicia /Medic		Decedent's Name (First, Middle, L	Lottie	Adele	Stokes		2. Date of Dea	Day	Year 2006	3. Time of Death 6:00 a. M
	Examin		4a. Facility Name (If not institution, gr	ve street and number)		4b. City, Town, o	r Location of Death	n	4c. Count	y of Death	
	Funeral			Sex 7. Age	(In yrs. last birthday	Randa11	If Under 24 Hrs.	8. Date of Birt	h		ace (State or Foreign
£.	Director		217-20-8112	1□ M 2□XF	94 Yrs.	Months Days	Hours Min.	(Month, Day	-1911	Count	ace (State or Foreign try). Va
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10	Od. Inside City Limits
	Maryl	tor	Md N	/A	Balto						1 XYes 2 No
	ith the	Olrec	10e. Street and Number			10f. Zip Code			10g. Citizen of		try?
	e 23s	ral	5608 Groveland	Avenue	vos in LLC 12	. Was Decedent of H	215	pactu Vas or No.	U S	A America	an Indian
336	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 Ie marked other than "naturel", or iteme 23e or 28e-f ehow other traumalic event, the Madical Evanting must be rotified at	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2X N If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:	o Rican, etc.)		ack, White, 6	
2-0	72 hou nature	eted	15. Decedent's l	ducation rade completed)	16a. Dec	edent's Usual Occup e kind of work done	pation during most of wor	rkina	16b. Kind of 8	Business/Ind	lustry
21215-0036	within ene. than "	mple	Elementary/Secondary (0-12)	College (1-4or 5-	r)	Dietary	d)		State	of Ma	aryland
9	e filed within at Hygiene. I other than '	e Co	12th grade 17. Father's Name (First, Middle, Las		/A		18. Mother's Nan	me (First, Middle,	Maiden Suma	me)	-
lan	should be nd Mental marked c	To Be	Buddy Epps				Lucinda	Alston			
Maryland	2 shoul and Me le mark		19a. Informant's Name/Relationship			ling Address (Street			•		Code)
	1 and 1 Health em 27 ther tr	1	Lucinda Queen - 20a. Method of Disposition	Duaghter	20b. Place of Disp	08 Grovela	and Avenu	Date Ballo	20c. Location		wn. State
Baltimore,	permit. Pages 1 and Department of Heall important: If item 2 eny injury or other once.		1 Surial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		cemetery, cre	ematory or other pla emorial Pa	1	20-2006	Laure1	, Md	, 3.0.0
Ball	Departiment Departiment importing eny in gence.		21. Signature Funeral Service Lice	ensee C & W	NH!	22. Name and Addre	iss of Facility 300 Wabas	March I h Avenue	-		21215
	*		23a. Parti. Enter the disease, or conshock, or heart failure. List only	y one cause on each lin	9.						Approximate Interval Between Onset and Death
19	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ارته	BSTUCTI	UE L	SUPE	DISE	NSE_	-
H	Examiner		1	Due to (or as a	consequence of):						
Ŧ	₽ ≓	ner	Sequentially list conditions, any leading to in redistricture. Cause. Enter Underlying	Due to (or as a	consequence of):						
V	executed in end ial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					-	
68760,	licate be executed physicien end s the burial-transit	edicalE		. d							
_	tificate og phy as the			<u> </u>		11.00 April 10.00					
P.O. Box	res that the death certif igned by the ettending be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 rponths? 1 Yes 2 to the 9 Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at to 9 □ Unknown	Fetel death 3	☐Ectopic pregnanc	У		1	ate of deliver	ry Day Year
	law requires that the es been signed by th 2 should be detache	þ	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause giv	ven in Part I.		bacco use cor es 2□No	3 Proba	e cause of death? ably 4 Unknown
Vital Records,	0 2 0	Completed			5174c			24a. Was autop	sy	Were autop prior to con death? 1 Yes	osy findings available appletion of cause of
/ital	ysiclen: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?	ļ				ath Check only o			~
o	physical this aldiding	- To	1 ☐ Yes 2 No 27 Manner of Death	Hospital: 1 ☐ Inpatier 28a. Date of Injury	nt 2 ER/Outpatre		4 Nursing H	fome 5 ☐ Resid)
	Attending r death. ector: After by the funer	ıtlon	1 Natural 5 Pending 2 Accident investigate	(Month, Day	Year) Injury	Wo	rk? Yes 2 □No	20d. Describe i	ow inquiry occu	1100	
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not determine		ry · At home, farm, s . (Specify)	street, factory, office		28f. Location (S City or Tow		ber or Rural	Route Number,
	e Hospite 24 hours e Funera letely fille	edical C	29a. Certifier Check only one) Check only	Physician: To the best of aminer: On the basis of and manner state	examination and/or i	ath occurred at the tri investigation, in my o	me, date and place opinion, death occu	e, and due to the curred at the time, c	cause(s) and m date and place	nanner as sta , and due to	ated. the cause(s)
	To the I	M	29b. Signature and title of certifier	Q B	· Che	29c, Licens	se number	80	29d. Date sign	ed (Month, L	Day, Year)
•	1		30. Name and address of person wh	completed cause of de	eath (Item 23a) (Type			,			06-
	') Sta	ate_	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	717 Pwa	KHE	(E(47)	- Kus	دمان	= 5(5/5
6	Regist	rar	JAN 2 3 2006	Beauty	I Louis	Sand Sand					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1248 PM CARBOROUGH EREDITH JANUARY 2006 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Future Care Chesapeake Arnold If Under 24 Hrs Anne Arunde1

9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days 1□ M 2ਊ F Yrs. 88 Director 719-09-1321 Oct 9, 1917 Virginia Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "netural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be restilled at 10d. Inside City Limits Director Anne Arundel Annapolis 1 ☐ Yes 2 ☑ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 85 Manresa Road Funeral 21401 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 end 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Rem 27 is marked other than "netural; or then eny injury or other traumatic event the Medical Experiments." 1♥ Yes 2□No If Yes, Give Year or Dates: 144–46 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk regional manager unk beverage 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Thomas Scarborough Estelle Nanette Herbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy James/daughter 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature I uneral Service Licensee Ronald S. Wade, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, theart failure. List only one cause on each line. Approximate Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 4DAYS ACUTE RENAL FAILURE Examiner Examiner the ettending physician and hed for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 ☐ Unknown ARTERIUVASCULAR DISCASE þ 24b. Were autopsy findings available prior to completion of cause of death? Completed DOMENTIA 24a. Was an autopsy performed? CORONARY ARTERY DISEASO 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Plece Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes /2 No 28a. Date of Injury (Month, Day Year) Certification: 27. Manna of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Perfect death. 1 atural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide To the Hospital or Atte within 24 hours efter de To the Funerel Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 19 certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) cause of death (Item 23a) (Type, Print) . 1 MD 8601 Vete RWSHIGHWAY SUITE 204 MILLERSVILLE MD 2/108

Registrar

State

31 Date filed (Month, Day, Year)

3 2006

32/Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician JANUARY 18 SELIG 2006 5:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LORIEN NURSING AND REHAB CENTER COLUMBIA HOWARD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month Day Year) 02/25/1937 Birthplace (State or Foreign Country) **Funeral** 1₩ 2□ F Months 095-28-4405A 68 NY **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 28a-f ehow 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo MD HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 7472 WEATHERWORN WAY 21046 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give X Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced If Yes, Give X Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) then Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient Important: If Itam 27 is marked other the any Injury or other treumatic event, Ima. 2006. 5+ AEROSPACE ENGINEER NASA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ALFRED RITA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TOBY SELIG / WIFE 7472 WEATHERWORN WAY - COLUMBIA, MD 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OLUMBIA MEMORIAL PARK 01/20/2006 COLUMBIA, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancer Colon **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ page 2 should be 2 No 3 Probably 4 □Unknown Completed 1 🗌 Yes peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete has autopsy 1 Yes 2 No To the Hospitel or Attending Physiclan: within 24 hours effer death.

To the Funerel Director: After this certifice funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mD) Kanm 00053709 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallant STE 210 BOWIE MD 1/AJ Fox lane CHAWLA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 2 3 2006 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Year Clotilde January 21 2006 Santoro 12:30 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Futurecare Chesapeake Aronld Anne Arundel If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 □ M 2 🗗 F 214-58-8021 19 1941 Italy Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Marvland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Highland Road U.S.A. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married ☐ Yes 2☐ No Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ₩idowed 4 Divorced Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bozzelli Pietro Ida 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 205 Highland Road Glen Burnie, Maryland 21060 Santoro Philip San 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State January 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St' Stanislaus 4 ☐ Donation 5 ☐ Other (Specify) 24.2006 Baltimore, Maryland 21. Signature of Funeral Service Lice 2. Name and Address, of Facility Dabrowski/Chojnacki Funeral Homes P.A. | 1005 Dundalk Ave. Baltimore, 1005 Dundalk Ave. Baltimore, Maryland 21224 23a Part1. Enter the disease, or complications that shock, or heart failure. List only one cause of Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 3 Probably 4 Onknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 D No 1 Tyes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28c. Injury al Work? 28a. Dale of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show any Injury or other traumatic event. It Medical Evalure traus to rotting at once.

Examiner attending physician and for use as the burial-transit Physician/Medical þ Completed Be 2 Certification:

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 ned by the at a detached for signed b s certificate has been sign director, page 2 should be Hospital or Attending Physician: pletely filled in by the funeral director, 24 hours after death.

Funeral Director: After this

within 2 To tha I

State Registrar

Medical

30 who completed cause of death (Item 23a) (Type, Print) Name and address of person

5 Pending investigation

6 Could not be

determined

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

29b. Signatu

4 Homicide

(Check only one)

31. Date filed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 16 Rev 6/95

			For State Registrar	State of M	aryland ,		artmen rtificat			ind Me		giene Rog. No.	006	0 366
1	Physici /Medic		1. Decedent's Name (First, Middle, L	Thout	45					-	2. Date of Dea		200 (3. Time of Death 8:304 M
	Examin		4a. Facility Name (If not institution, g Manor Care Nur 5. Social Security Number 6.	sing/Fal			Bal	Town, or time	Location of Dre		3. Date of Birt		N/A	
	Funeral Director		247-58-2795 Usual Residence of Decedent	1 M 2 F	79	Yrs.	Months	Days	Hours	Min.	Jan. 2	y, Year)	C	thplace (State or Foreign ountry)
	he Maryla 28a-f shov cliffed at	Director	Maryland N/A 10e. Street and Number		Balt	timo	re			·				10d. Inside City Limits 1 ☐ Yes 2 ☐ No X
	3a or 3	I Dir	1202 Woodyear	Street			10f. Zip	212	217			USA	zen of What C	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any righty or other traumatic avant, the Medical Erain art must be notified at ances.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 Tyes 2 If	?		Was Deced If Yes, spec 1 ☐ Yes	dent of His		gin? (Spec , Puerto R	fy Yes or No- ican, etc.)		14. Race - Am Black, Whi	te, etc.
Baltimore, Maryland 21215-0036	hin 72 hour e. an "natural Medical Er	Completed b	3 ₩ Widowed 4 □ Divorced 15. Decedent's (Specify only highest of the property of the property (0-12)	Year or Dates: Education rade completed) College (1-4or		(Give	dent's Usua kind of wo DO NOT us	rk done d	urina most	of working		16b. Ki	nd of Business	/Industry
nd 21	be filed wit tal Hygiend d other thi event, the	Be	8th grade 17. Father's Name (First, Middle, La.		Sl	nipp	inq	& Re			Cler First, Middle,	< Wa	rehou	
r <u>yla</u>	d Men narka natic	ဥ	Madison Davis 19a. Informant's Name/Relationship	(Typo Print)	16.	IOb Mailie	n Address	(Change of			ane Po		Town, State,	7: 0: 4)
Z Z	is 1 and 2 s of Health an item 27 Is i other traus		Earlene Jones/											and 21217
ore,	of Hez of Hez fitam rotha		20a. Method of Disposition	□ Removal from State	20b. Place	e of Dispo	sition (Nar. matory or o	ne of		Da			cation - City or	
Ë	t. Pag rtment rtant;		`4 Donation 5 Other (Spec	cify)	Wood				ery 1					Maryland
Bal	Depar Import		21. Signature of Funeral Service Lic	turin		5	240	Reis	sters	stown	ı Rd I	Balt		uneral Home ,Md 21215
	Physician	,	23a. Part1. Piter the disse, or co sheaf, or heart faill, e. List on Immediate Cause (Final disease or condition resulting in death)		d the death. I									Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as	a consequen	ce of):								
	± q	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequen	ce of):								
8760,	icate be executed physician and s the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequen	ce of):								
687	ificate g physi as the	edical		d										
.O. Box	the death certific y the attending p iched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal de	ath 3	Ectopic pr Other (sp					2	23d. Date of de Month	olivery Day Year
<u>α</u>	quires that the d n signed by the uld be detached	þ	Part II. Other significant conditions	contributing to death t	out not resultin	ng in the u	nderlying c	ause give	in in Part I.			obacco u (es 2[o the cause of death?
l Records,	The law requires that sate has been signed b page 2 should be deta	Completed									24a. Was autop perfo 1 Yes		prior to death?	utopsy findings available completion of cause of
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				0#10		of Death (Check only o	ne)		
of	Phys this al dii	tlon; To	1 ☐ Yes 2 ☑ No 27. Manger of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Inju	ury 28	Outpatien b. Time of Injury		8c. Injury Work	at	28	e 5 ☐ Resid d. Describe h		S □Other (Spe y occurred	ecify)
Division		Certification;	3 Suicide 6 Could not 4 Homicide determine	ad 286. Place of in	jury - At home tc. (Specify)	, farm, str	eet, factory	, office		28	If. Location (S City or Tox			tural Route Number,
	To the Hospital or within 24 hours effe To tha Funaral Dir completely filled in	edical (29a. Certifier 1 Certifying (Check only one) 2 Medicel Ex	Physician: To the best aminer: On the basis of and manner st	or examination	dge, death and/or in	h occurred vestigation	at the tim , in my op	e, date and inion, deat	d place, an	d due to the d	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	elle mo			290	. License	number	7	+7	29d Date	e signed (Mon	th, Dey, Year)
1	N		30. Name and address of person wh	o completed cause of	death (Item 23	Ba) (Tyne	Print) L	ううら	15	7-2	TH.	an	115.	7006
	9		300 ARMORY	PC, Sui	(t)	39	BA	CTIA	TOPLO	2 3	7) Z	(50	7	
: -	Sta Regist		31. Date filed (Month, Day, Year) JAN 2 3 20	32. Regist	rar's Signature	Con								

			For State Registrar		State of	of Maryla		artmei rtifica				/lental		ene g. MG. ()	n s	0.1	367
			Decedent's Name (First, Manual Control of the	Aiddle, Last)								of Death	1	0.0	3. Ti	me of Death
Ŧ.	Physici		Phoebe W. T	roup								.Tanı		Day 17, 2	Year OOA	7.0	0 AM ^M
	/Medic Examir		4a. Facility Name (If not insti		street and nu	mber)		4b. City	, Town, or	Location	of Death			T	nty of Deat		O IIII
6	LAUTIN		Homewood at	Will	iamspo	rt		1	Villi	amsp	ort			Was	hingt	ton	
	Funeral		5. Social Security Number	6. Se	х	7. Age (In yrs	. last birthday,	If Unde	r 1 Year	If Unde	r 24 Hrs.	8. Date	of Birth				tate or Foreign
	Director		577-28-6171 Usual Residence of Deceder]М 2∰Г	83	Yrs.	Months	Days	Hours	Min.	Oct	th, Day, 28,	1922			ginia
	land ow		10a. State 10b. Co			10c. C	ity, Town or L	ocation								10d. Ins	de City Limits
	Man	ţŏ	MD Wasi	ningto	on	W	illiams	sport								1 🗀	Yes 2 No
	28a	Director	10e. Street and Number			1		-	p Code				10	g. Citizen o	of What Co	untry?	
	3e or		16505 Virgin	i	nuo C	252			2.1	1795				TIO			
	ne 2	era	16505 Virgin:	La Ave	12. Was Dec	edent Ever in I	J.S. 13.	Was Dece	- Contract -		rigin? (Sc	ecify Yes	or No-	USA 14. R	ace - Ame	rican Indi	an,
10	r lter	by Funeral	1 ☐ Never Married 2 ☐	Married	Armed Fo	orces? 2t☑No		Was Dece If Yes, spe		in, Mexica	an, Puerto	Rican, e	tc.)		lack, White		
036	urs a		3 ₩idowed 4 Divo	rced	If Yes, Gi Year or E	ve		1 🔲 Yes	2 X No	Specify	<i>/</i> :			Spec	ity:whi	te	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23e or 28e-f ehow ta Medigal Examinar must be notified at	Completed		edent's Edu			16a. Dece						1	6b. Kind of	Business/	Industry	
218	hin 7	pie	(Specify only h	· · · · ·	College (life.	DO NOT	use retired	during mo ()	IST OF WORK	ang					
21	d with	on	12		0	,	Вос	okkee	per				1	Nation	nal G	eogra	aphic
	E H	Be (17. Father's Name (First, Mic	ddle, Last)						18. Moth	ner's Nam	e (First, I		laiden Sum			•
ā	Aenta Aenta rked	To	Chester Pil	ke Wad	le					Mar	y E1	izab	eth I	Dyche			
Maryland	ges 1 and 2 should be filed within 72 hc to f Health and Mental Hygiene. If Item 27 is marked other than "nature or other traumatic avent, the Medical		19a. Informant's Name/Rela	tionship (T)	vpe, Print)		19b. Maili	ing Addres	s (Street a	and Numb	ber or Ru	ral Route	Number,	City or Tow	m, State, Z	(ip Code)	
	s 1 and 2 if Health Item 27 I		Calvin Trou	e/son			251	Locu	st Wo	ood P	lace?	Sil	ver S	Spring	g, MD	209	904
re	of He		20a. Method of Disposition			1	Place of Dispe	osition (Na	me of other plac	e) [Date	2	Oc. Location	n - City or	Town, Sta	ite
Ĕ	Pages nent of P ant: If Ite		1 ☐ Burial 2 ☐ Crema 4 ☑ Donation 5 ☐ Oth			tate		,	,	1							
Baltimore,	그 는 는 듯		21. Signature of Euneral Ser ROnal	yiceLicens	99 da/ x	Hraeto	r 9	2. Name a	nd Addres	s of Faci	Xard	655	W 1	Baltin	nore	Stra	a t
œ	Depar Impo		Milan	111		110		altim			2120	Control of	VV • J	Dalti	nore	Dere	
1	*		23a. Pan1. Enter the disease show, or heart failure.	or come	cation that	caused the dea							tory arre	st,		Appro	kimate Il Between
-	Physician		Immediate Cause (Final	List Offig O	-											Onset	and Death
3	/Medical		disease or condition resulting in death)	-		(or as a conse										0 do	12.
	Examiner			- 1	0	al Fa										m	the
	o	Je.	Sequentially list conditions, if any, reading to immediate			(of as a conse										77107	11/3
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1	Art	eriosc	12roti	e Va	scu.	lar	Dis	eas(2			yeo	CS
Ć,	cate be executed physicien end the burial-transit	Exa	resulting in death) Last			(or as a conse							-			1	
8760,	ysicie y bul	dicai			d												
9	ifficat g phy as th	ed												1			
Вох	The law requires that the death certific ale has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnar	ıt 2		tcome of pregr		70						23d. 0	Date of deli	very	
	death e atte d for	icia	in the past 12 months?		4□Preg	oirth 2 ☐ Fet nant at time of		_Ectopic p ☐ Other (s						N	Month	Day	Year
P.0	by the de	hys	9 ☐ Unknown		9□ Unkn	own											
	ned t	by P	Part II. Other significant con	editions co	ntributing to d	eath but not re	sulting in the u	underlying	cause give	en in Part	1.	23e	. Did toba	acco use co	ntribute to	the caus	e of death?
rds	quires n sign ald be	D D	Congestive	Hear	· + F	allur	و						1 🗆 Yes	2 1 No	3 🗆 Pro	obably	4 □Unknown
Vital Records,	w requir been si should	Completed	Breast Co	ancel	_							24a	. Was an	241	o. Were au	topsy find	ings available
Re	The lav	Ĕ											autopsy perform	ed?	prior to death?	completion	of cause of
a	icien: Th certificate rector, pag		25. Was case referred to me			1770				20 01			-	No	1 ∐ Yes	2 🗆 No	
Ξ		o Be	examiner?		Hospital:	Inpatient 2] ER/Outpatie	nt 3 D	Othe		4	th Check	-				
ō	g Phys ter this neral di	1-3	27. Manner of Death	-	28a. Date	of Injury	28b. Time of		28c. Injun	/ at	iursing no			nce 6 🗆 O		iny)	
o	iding Pt th. : After th funeral	tio	1 ☑Natural 5 ☐ P. 2 ☐ Accident in	ending vestigation	(Mor	th, Day Year)	Injury	М	Work	k? Yes 2.⊑]No						
Division	Attended to death octor:	Certification:	3 ☐ Suicide 6 ☐ C	ould not be	28e. Place	of Injury - At i	nome, farm, st	reet, facto	ry, office			28f. Loca	tion (Stre	et and Nur	nber or Ru	ral Route	Number,
D	after Direction of the direction of the	ert	4 Homicide		build	ing, etc. (Spec	ify)					City	or Town,	State)			
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier 1 Cer	tifying Phy	sician: To the	best of my kn	owledge, deal	th occurred	at the tim	ne, date a	ınd place,	and due	to the cau	use(s) and r	manner as	stated.	
	8 Ho 24 t 6 Fu letely	Medical	(Check only 2 Med one)	lical Exami	ner: On the t	asis of examin	ation and/or in	nvestigatio	n, in my op	pinion, de	ath occur	red at the	time, dat	te and place	e, and due	to the ca	use(s)
	Vithir Comp	Me	29b. Signature and title of ce					29	c. License	e number			29	d. Date sigr	ned (Monti	n, Day, Ye	ear)
			Cyptha	Kutt	ner-	Sand,	mp		D 4:	745	1		Jo	inuar	y 17	200	6
			30. Name and address of pe	rson who c	ompleted cau	se of death (Ite	m 23a) (Type,	Print)	- 0	. , ,	1	0	h c	. () 1		-
			cynthia Ku					-214	- 79	rac	1120	10 L	n u r M	CN	land	121	742
70.0	Sta	ite	31. Date filed (Month, Day	rear)		Registrar's Sign		W .		J	, , , 	~~~	1				-
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	Physici	an	Decedent's Name (First, Middle, L MADV	ast)	TOI	חחר		2. Date of Death Month	Day Yea	3. Time of Death
	/Medic Examin	4	MARY 4a. Facility Name (If not institution, g.	Ve street and number)	IKI	PPE 4b. City, Town, o	or Location of Death	January	18 Zoo 4c. County of De	
	307	ei	Sinai Hospital	of Baltimor	e n yrs. last birthday		nore Cit	y		N/A Birthplace (State or Foreign
	Funeral Director			1□M 2□F	89 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, NOV.1,19	916	Country) MD
	land ow		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or L	ocation				10d. Inside City Limits
	with the Maryland a or 28a-f show Leanuillied at	ctor	MD BAL	.TIMORE	OWIN	GS MILLS				1 Tyes 2 No
	vith the	Director	10e. Street and Number	DDIVE		10f. Zip Code	01117	10	og. Citizen of What	•
	death with	Funeral	3510 AVERY HILL	DRIVE 12. Was Decedent Eve	rin IIS 13	Was Decedent of I	21117	pecify Ves or No-	14 Bace · Ar	USA merican Indian.
36	5 Z Z	by Fun	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces?		If Yes, specify Cub 1 ☐ Yes 2 💢 No	Hispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)	Black, W	
Mary 215-003	72 hours "naturel",		15. Decedent's (Specify only highest g	Education rade completed)		dent's Usual Occup	pation during most of work	kina	16b. Kind of Busine:	
Trippe, Mary Maryland 21215-0036	c _ g	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)		OWN HOME	
and in	ges 1 and 2 should be filed within to Health and Mental Hygiene. It if flem 27 is marked other than or other traumatic event, the Mental Mental Health and M	To Be C	17. Father's Name (First, Middle, Las	st)	14.00	DCON		e (First, Middle, M	faiden Surname)	VP00D
i p	should nd Men marke imatic	P P	JULIUS 19a. Informant's Name/Relationship	(Type, Print)	JACO		ROSE	ral Route Number.	City or Town, State	KROOP a. Zip Code)
Ma N	is 1 and 2 soft Health are item 27 is other trau		STUART TRIPPE /		3510	AVERY H			MILLS,	
Baltimore,	ages 1 ant of He it: if iten y or oth		20a. Method of Disposition 1 💢 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	Removal from State		osition (Name of matory or other pla IVE RUDON	CO) A EKETIN	Date 2 20/2006	ROSEDALI	
altir	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service 10		2	2. Name and Addre	ess of Facility SOI	LEVINSO	N & BROS	., INC.
	89 2 2 9	. 30	/ Way							, MD 21208
	Physician		23a. Part1. Enter the disease of co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	by one cause on each line. Chronic O Due to (or as a co					est,	Approximate Interval Between Onset and Death
88760,	/Medical Examiner be executed bhysicien and the private transit the private transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	onsequence of):					
P.O. Box 6	ath cer ittendin or use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnand in the past 12 mopules? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of o	delivery Day Year
rds, P	quires that the de n signed by the a uld be detached f		Part II. Other significant conditions Congestive H	contributing to death but near Failu		underlying cause gr	ven in Part I.	23e. Did tob 1 ☐ Ye	~	to the cause of death? Probably 4 □Unknown
Division of Vital Records,	The law requires the law requires the lass been spage 2 should	Completed by	J					24a. Was ar autopsy perform 1 Yes 2	/ prior t	
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					th (Check only one		
on of \	ding Physician: n. After this certifica funeral director,	tlon: To	1 Yes 21 No 27. Manner of Death 1 Natural 5 Pending investigate	Hospital: 1 X Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatie 28b. Time ear) Injury	of 28c. inju	ry at	ome 5 Resider 28d. Describe ho	nce 6 □Other (S _i w injury occurred	Decify)
Divisi	To the Hospital or Attending within 24 hours atter death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not determine	be Oge Place of Injury	· At home, farm, s Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	28f. Location (Str City or Town		Rural Route Number,
	Hospital 24 hours a Funeral letely filled	edical C	29a. Certifier (Check only one) 1 Certifying I	Physician: To the best of n aminer: On the basis of ex and manner stated	amination and/or in	th occurred at the tinvestigation, in my	me, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner ite and place, and d	as stated. ue to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and the of certifier	_		29c. Licens	se number	29	d. Date signed (Mo	nth, Day, Year)
			Malero	mD		Da	63282	J	arrany 18	2006
	10		A 1 . 1 . 1/ . 1	o completed cause of deat	h (Item 23a) (Type	Print)	nue Bult	0 (a NA)	J	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Wie Five	nue but	more IVII	راداع ب	

Months

7. Age (In yrs. last birthday)

85

Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs. Months Days Hours Min.

BALTIMORE CITY

Hours

State of Maryland / Department of Health and Mental Hygiene

2. Date of Death

20, 2006

4c. County of Death

11:20 A.

Birthplace (State or Foreign Country)

MARYLAND

10d. Inside City Limits 1 Yes 2 No

10g. Citizen of What Country?

<u>USA</u>

14. Race - American Indian, Black, White, etc. Specify: WHITE

16b. Kind of Business/Industry BALTIMORE COUNTY SCHOOL SYSTEM

18. Mother's Name (First, Middle, Maiden Sumame)

JANUARY

8. Date of Birth (Month, Day, Year)

5/8/1920

MICHALENA KAMINSKI

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2610 SCIENTIST CLIFFS RD. PORT REPUBLIC, MD

20c. Location - City or Town, State

22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A.

TOWSON, MD 21286

Approximate Interval Between Onset and Death

23d. Date of delivery Month Day

Year

3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No

performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1-23.06

29b. Signature and title of certifier 29c. License number Screan & Nolaw is D0025010

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. NOCAN IMP 8831 SATYR HILL RD, SUITE 100 PARKVILLE, MO SERENA

State Registrar

10

31. Date filed (Month, Day, Year) 3

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

220-03-0473

Usual Residence of Decedent

EDWARD S. ULANOWICZ

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

1 M 2 □ F

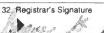
Physician

/Medical

Examiner

Funeral

Director





		Please I	ype or Print					•			
		For	State of Man	yland /	•			Mental Hy	/gieme	006	01370
		1 - State Registrer			Certifica	te of L	Death		Reg. No.	000	01070
		1. Decedent's Name (First, Middle, Last)	1	, \				2. Date of D Month	eath Day	Year	3. Time of Death
Physici /Medio		trances		\mathcal{U}	agne			Januar		2004	12:159 · M
Examir		4a. Facility Name (If not institution, give s		12			Location of Death	1	4c.	County of Deat	h + A
The state of the s		BWMC 30	1 Hospida	706	· GI	en	Burn	e		Anna	rundel
Funeral		Social Security Number		In yrs. last	birthday) If Und Month	er 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth	9. Birti	hplace (State or Foreign untry)
Director		217-40-7591	M 2804F	92	Yrs.	Days	TIOUIS WINT.	Oct 24		13	MD
p _		Usual Residence of Decedent									
nylar how	L	10a. State 10b. County	11	oc. City, 1	own or Location						10d. Inside City Limits
e Ma la-fa	cto	MD Anne Aruno	iel	Pasa	dena			-			1 ☐ Yes 21€No
다 다 or 26	Director	10e. Street and Number			10f. 2	Zip Code			10g. Citi	zen of What Co	untry?
d 21215-UU36 filed within 72 hours after death with the Maryland Hygiene ther than "natural", or items 23a or 28s-f ahow ther, the Medical Examinar must be notified at		586 Pine Drive				21122			USA	A	
dea me	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Dec	edent of Hi	ispanic Origin? (S In, Mexican, Puert	pecify Yes or N	0-	14. Race - Ame Black, White	
after after O		1 Never Married 2 Married	1 Yes 2XXNo			XX No	Specify:	,		Specify:	0, 010.
Paris Del	d b	• 3√√Widowed 4 □ Divorced	Year or Dates:		12.03	N-A	opeony.			Wh:	ite
5-C	Completed by	15. Decedent's Edu (Specify only highest grade	cation e completed)	16	Sa. Decedent's Us (Give kind of v	sual Occupa	ation during most of wor	rkina	16b. Kii	nd of Business/	Industry
	npl	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT	use retired)				
Z week	Co	8			Sales				Reta	ail	
= ~ - 0 5	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nar	ne (First, Middl	e, Maiden	Sumame)	
rked b	일	Frank B. Wood					Lucy Be	rry			
Maryland 21215-UU36 nd 2 should be filed within 72 hours after death with the Marylan tit and Mental Hygiene. 27 le marked other than "natural", or items 23s or 28s-f ahow traumatic event, the Medical Examinat must be notified at		19a. Informant's Name/Relationship (Ty	pe, Print)		_		and Number or Ru			r Town, State, 2	Zip Code)
and and alth		Larry Wagner Son	n		586 Pine	Driv	e, Pasad	ena, MD	211	122	
Baltimore, Marylar permit. Fages 1 and 2 should be Department of Health and Menta important; if them 27 1e marked any higury or other traumatic ev		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	amanal from State	20b. Place ceme	of Disposition (Natery, crematory of	iame of r other plac	ry Jan	Date	20c. Lo	cation - City or	Town, State
Baltimore, permit. Fages 1 ar Department of Hea Important: If them any injury or othe		4 Donation 5 Other (Specify)	emovariiom state	Loudo	n Park C	emete	ry Jan	24, 200	ь ва	alto., N	4D
mit.		21. Sign up of Funeral S pace cense	e ()		22. Name	and Addres	s of Facility	Ti A			
		K Gregory Fink	MO114	48	426 C	runer rain	l Home,	Glen Bu	rnie,	MD 21	1061
· * * * * * * * * * * * * * * * * * * *		23a. Pany. Enter the dise set, or compli show or heart failure. List only or	cations that caused th	e death. D	o not enter the m	ode of dyin	g, such as cardiad	or respiratory	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final		age.	Renai		ease				Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a c								
Examiner			(,							
Late of the	ē	if any, leading to immediate	Due to (or as a c	onsequenc	ce of):						
pet I	声	cause. Enter Underlying Cause (Disease or injury that initiated events									
60, be executed sician and burial-transit	Examiner	resulting in death) Last	Due to (or as a o	onsequenc	ce of):						
\$8760, icate be ex physician s the buria	cai		1								
Records, P.O. Box 687 The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	Physician/Medic										
Box eath certi	M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of						2	23d. Date of del	ivery
Beath death atte	cia	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 [4 Pregnant at tire						- 11	Month	Day Year
P.O. that the de ed by the detached	ysi	9 Unknown	9□ Unknown								
that the ded b	y P	Part II. Other significant conditions cor	atributing to death but r	not resultin	g in the underlying	g cause givi	en in Part I,	23e. Did	tobacco u	ise contribute to	the cause of death?
ds, uires uires ta be	d by							1□	Yes 2	□No 3□Pr	obably 4 Unknown
cord w requir been si	Completed							24a. Wa	s an	24b Were au	itopsy findings available
Record								auto	opsy formed?	prior to death?	completion of cause of
Cale								1 Yes		1 ☐ Yes	2 □ No
Vit siclal certi	Be	25. Was case referred to medical examiner?	lospital:			Oth	er:				
Talifi Property Of	. To	1 Yes 2 No	28a. Date of Injury		Outpatient 3	28c. Injun	4 Nursing F	28d. Describe		6 Other (Spec	city)
ding h. After	tion	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear)	Injury M	Worl	k? Yes 2 □No			,	
isi deat ctor:	ica	3 Suicide 6 Could not be	28e. Place of Injury	r - At home		l		28f. Location	(Street an	d Number or Ru	ural Route Number,
Division of Vital Records, or or Attending Physician: The law requires tafer death. Director: After this certificate has been signed in by the funeral director, page 2 should be	Certification:	4 Homicide determined	building, etc. ((Specify)	, 14111, 511551, 1451	017, 011100		City or To	own, State)	
pital purs a eral		29a. Certifier 1/2 Certifying Phys	sician: To the best of r	my knowled	fine death occurr	nd at the tim	ne, date and place	and due to the	2 021150(5)	and manner as	chatad
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only 2 Medical Examinations)	ner: On the basis of ex and manner state	xamination	and/or investigati	on, in my o	pinion, death occu	irred at the time	date and	place, and due	to the cause(s)
thin the male	Me	29b. Signature and title of certifier	and marrier state	<u>. </u>	2	29c. License	e number		29d. Dat	e signed (Monti	h, Day, Year)
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		rulle lasse		-1 2	-) (7	600	11 473		Janu	acty ox	,,,,,,
Z		30. Name and address of person who co	ompleted cause of deal	r land	a) (Type, Print)	say.	SI IVET -	Spring	MI	209	104
129 48 36 800	ate	31. Date filed (Month, Day, Year)	32. Registrar's					<u>'</u>			
Regist		IAN 2 3 28		_	Coast						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JANUAR 9 **Physician** WOODWARD 20,2006 HARRY 9400 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner CROMWELL CONTER-ELDAR CARE GENESIS BACTIMORE PARKVILLE If Under 24 Hrs. 8. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5/20/1916 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 1 M 2 □ F Days Months Hours Min Director 029-05-3731 89 MASSACHUSETTS Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28e-f show must be notlined at 1 ☐ Yes 2 No Director BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8719 LACKAWANNA AVENUE 21234 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. th end Mental Hygiene. 7 is marked other than "neturel", or flen treumatic event, the Medical Examine. 1 Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10TH GRADE FACTORY WORKER MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY WOODWARD ELIZABETH ALBONE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VIVIAN E. WOODWARD/WIFE 8719 LACKAWANNA AVE. BALTIMORE, MD item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: if it ŏ 1 □XBurial 2 □ Cremation 3 □ Removal from State DULANEY VALLEY MEM. GAR. 1/24/06 COCKEYSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a CONGESTIVE HENRI Examiner Due to (or as a consequence of) Physician/Medical Examine CARDIOVASCACA THAROSCLOPOTE for use es the buriel-transit Attending Physicien: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uee contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No -L2/FEINERS DISEASE Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? P4CMONARY OBSTRUCTIVE completion of cause of death? 1 765 2 4NO 1 ☐ Yes 2 ☐ No funerel director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Vursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred : After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident eftar death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Š 4 Homicide ò fillad in To the Hospital within 24 hours To the Funeral (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completaly (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

State

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) M1) Wil 50/6 Mid-41CHAR J-31. Date filed (Month, Day, Year)

JAN 2

3

2006

29b. Signature and title of certifier

32. Registrar's Signature 6 Part

WARRY WOODS FD, BARINGE, MD 8813

29c. License number

331189

29d. Date signed (Month, Day, Year)

JANUARY 20, 2006

Registrar DHMH 17 Rev 1/2001 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year Patricia Ann Walton January 7:14 PM /Medical 2006 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3000 Gallery Place Waldorf If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Hours 1 ☐ M 2 🂢 F Director 63 Yrs 220-38-4214 1942 Washington DC July 10, Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location or itema 23a or 28a-f ehow 10d. Inside City Limits the Medical Exacultrar rount be notified at Director 1 ☐ Yes 2√ No MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3000 Gallery Place 20602 USA death Funerai Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iten any injury or other treumatic event, the Manical Exemi Black, White, etc. l ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 domestic private homes 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 2 Alfred Santilli Anna Magnolia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Courtney/friend Box 229 Marbury, MD 20658 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 MOther (Specify) in state 21. Signature Euneral Scyce Licensee Ronal d S. Wade State Anatomy Board 655 W. Baltimore Street now Baltimore, MĎ 21201

23a. Parti Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21201 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No should be detached 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No. 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 2 No Hospital: Other: 1 🗌 Yes 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of Death 28a. Date of Injury (Month, Day Year) 27. Manne 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a Certifier 29b. Signature and title of certifyer 29c. License number 29d. Date signed (Month, Day, Year) 31 hame and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

a

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

			For State Registrar	State of Ma	,		nt of Healtl Ite of Deal			g. No.	6 0137	714
Æ.			Decedent's Name (First, Middle, Last	st)					2. Date of Death		3. Time of D	eath
	Physicia		Joseph Edward Da	nsby Ward					January		6 4:35 A	A. M
	/Medic Examin	100	4a. Facility Name (If not institution, give			4b. Cit	y, Town, or Location	on of Death		4c. County of		
	LAdillii	C1	617 Winans Way			E	altimore					
	Funeral	-	Social Security Number 6. S	ex 7. Age	(In yrs. last bir			der 24 Hrs.	8. Date of Birth	Vans)	9. Birthplace (State or a Country)	Foreign
	Director		170-32-0274	X]M 2□F	67	Yrs. Month	s Days Hou	rs Min.	June 14	, 1938 E	Pennsylvani	Ĺа
			Usual Residence of Decedent									
	ylang ylang		10a. State 10b. County		10c. City, Town						10d. Inside City	
	Mar Firet	to	Maryland		Balti	more					1 X Yes 2	≧∐No
	r 28.	Director	10e. Street and Number			10f. 2	Zip Code		10	g. Citizen of Wh	at Country?	
	h wit		617 Winans Way				21229			USA		
	hours after death with the Maryland Lural', or ttems 23a or 28a-f show at Exactinat must be notified at	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Dec	pedent of Hispanic pecify Cuban, Mex	Origin? (Sp	ecity Yes or No-		American Indian, White, etc.	
۵	after or tte	J.	1 Never Married 2 Married	1 X Yes 2 □ N	0	1 2	2⅓No Spec				Black	
3	rail;	t by	3 Widowed 4 Divorced	Year or Dates: 1	956-59		202110 0000			Specify.	DIACK	
ဂ ဂ	72 h	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a.	(Give kind of	sual Occupation work done during r	most of work	ing 1	6b. Kind of Bus	iness/Industry	
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7	ygier yerth t, II.	Š		4	\$ys	tems Te	ch Speci			MTA of N		
	d oth	Be	17. Father's Name (First, Middle, Last)	1					e (First, Middle, N		,	
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a	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione. Important: if item 27 is marked other than "natural; or items 23a or 28a-1 ehow any injury or other traumatic event, in a Madical Examination in a page.		19a. Informant's Name/Relationship (Type, Print)	19b	. Mailing Addre	ss (Street and Nu	mber or Run	ai Route Number,	City or Town, S	tate, Zip Code)	
≥.	and ealth n 27		Carmen A. Ward	Wife			s Way, B				in a Taura State	
ore	of H of H if ite		20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	cemete	f Disposition (f ry, crematory o	r other place)		141		ity or Town, State	
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Baltimore,	parti port y inj		21. Signature of Funeral Service Licer	159000	1	22. Name F11D 6	and Address of Fa	of Ca	rling As atonsvil	nton Sci le. Inc.	wah Witzke	5
m	20 = 20		Demard	Kelson	calle)	1630 E	dmondson	<u>Avenu</u>	ie; Catoi	nsville,	MD 21228	
7 12			23a. Part1. Enter the disease, or com- shock, or heart lailure. List only	plications that caused one cause on each lin	the death. Do	not enter the m	ode of dying, such	n as cardiac	or respiratory arre	est,	Approximate Interval Between	een
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	/Medical		resulting in death)		consequence		· · ICICI	V C 607	1	1		
	Examiner			b								
		ner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	of):						
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9	tifica ng ph as th	Jed	IF FEMALE:									
ŏ	h cer endir	Ş	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		3 □Ectopio	pregnancy			23d. Date		ear
.О. Вох	deat	icia	in the past 12 months? 1 \(\sum \) Yes \(2 \sum \) No	4☐Pregnant at 9☐ Unknown		5 Other				Mont	h Day Ye	dai
Ö.	by the	hys	9 Unknown									
ري م	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use a	by Physician/Me	Part II. Other significant conditions	contributing to death be	ut not resulting i	n the underlyin	g cause given in P	art I.			oute to the cause of de	
Division of Vital Records,	w require been sig should b								1 ☐ Ye	s 2□No 3	Probably 4/SU	nknown
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Re	he ta	Completed							autopsy perform	ned? de	ath? ☐ Yes 2 ☐ No	use oi
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o	Phy or this		27. Manner ol Death	28a. Date of Inju	y 28b.	Time of	28c. Injury at Work?		28d. Describe ho			
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/18	Attending r death. ector: Alter by the fune	fice	3 Suicide 6 Could not b	286. Place of Inju		arm, street, lac	tory, office		28l Location (Str City or Town		r or Rural Route Numb)9 <i>r</i> ,
á	after after i Dire	Certification:	4 Homicide	building, etc	з. (Зр в спу)				City or Town	, State)		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying P	hysician: To the best	of my knowledge	e, death occur	ed at the time, dat	e and place,	and due to the ca	iuse(s) and man	ner as stated.	
	P Ho Fu letely	edical	(Check only 2 Medical Example)	miner: On the basis of and manner sta		nd/or investigat	ion, in my opinion,	death occur	red at the time, da	ate and place, ar	nd due to the cause(s)	
	ro th within ro th compl	Me	29b. Signature and title of certifier				29c. License numi	ber	25	9d. Date signed	(Month, Dey, Year)	
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d	7		30. Name and address of person who	completed suse of d	eath (Item 23a)	(Type, Print)			-	1.1		
7)		Carole Willen	MP MM	15.01	11 may	e BALT	W BB	o VVV	1)2122	29	
	St	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	- 1		4 1010	, , ,			
# S	Regist		31. Date filed (Month, Day, Year)	2006	we S.	Little Co.						

06-00167 B.K.S Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible. Amend Unpend item#1,23a,111,27,23a-1,perff:,4852,2/6/00 11
State of Maryland / Department of Health and Mental Hygiene SHARILYN WELCH 1 - For State Registrar Certificate of Death Reg. No: 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 2006 Sharilyn Welch JAN. 0245 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE RANDALLSTOWN 213 GREENFERN WAY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 ☐ M 2 DEF Yrs. 08-21-1969 Ohio **Director** 212-98-9615 36 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County 28e-f show rel', or items 23a or 28e-f shore examiner insist be notified at 1 ☐ Yes 2 X No MdBaltimore Randallstown Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21133 U.S.A. 213 Greenfern Way death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Peges 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify: Specify: White δ 3 ☐ Widowed 4 ☑ Divorced "nature!" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other then "natur 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Compi Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Is marked Sandra Helmick Darrel Gallihue 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 : Depertment of Health ar Important: if item 27 Is eny Injury or other trau once. 58 Kiser Road Grayson, Kentucky 41143 e of Disposition (Name of Date 20c. Location-Darrel Gallihue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01-10-2006 Baltimore, Maryland Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wise Funeral Services, P.A. 700 S. Beechfield Ave Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heroin Intoxication Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Dther (specify) 1.☐ Yes 2 ☐ No 9 X Unknown o 9□ Unknown of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Cocaine use 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 △ Yes 2 □ No 1X Yes 2□ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) AT SCENE 1 X Yes 2 □ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury Find (Month, Day Year) 28b. Time of Find Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Division 1 Natural 5 Pending 1 ☐ Yes XXX No investigation 2:35 1/7/06 A unk 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 213 Green Fern Way 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Baltimore, MD Found at residence Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of peath (Item 23a) (Type, Print)

2006

29c. License number

O.C.M.E

111 PENN STREET, BALTIMORE, MARYLAND 21201

29d. Date signed (Month, Day, Year)

JAN. 7, 2006

			1 - State Registrar	State of Marylar		artment of tificate o			ental Hy	Reg. N	. 0 0 0	3. Time of Death
1	Physici	an	Decedent's Name (First, Middle, Last						Month	Da	y Year 2006	10:00A M
,	/Medic		Leroy Stanley Ar	street and number		4b. City, Town	or Location	of Death	Januar	-	c. County of Death	
	Examin	er	8915 River Island			Savage				Ho	oward	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.	last birthday)	If Under 1 Year Months Day		24 Hrs.	8. Date of Bi (Month, D	rth	9. Birth	place (State or Foreign ntry)
	Director		578-56-8885	M 2□F	61 Yrs.	Months	3 Hours	IVOIT.	Jan 10	19		ington D.C.
	pu .		Usual Residence of Decedent 10a. State 10b. County	10c C	ity, Town or Lo	cation			-			10d. Inside City Limits
	Aaryle	ō										1 ☐ Yes 2 ☐ No
	28a-	ect	Maryland Howard 10e. Street and Number	bav	age	10f. Zip Code	,			10g. C	ilizen of What Cou	ntry?
	3a or	٥	8915 River Island	Drive #102		20763				USA	1	
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ahow ta Medical Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in t	J.S. 13.	Was Decedent o	f Hispanic Or	igin? (Spe	cify Yes or N	0-	14. Race - Ameri	
9	or its		1 Never Married 2 Married	Armed Forces? 1 XYes 2 No If Yes, Give		fYes, specify Ci 1 □ Yes 2 🛣 N			ricall, etc.		Black, White	
8	Jrai',	d by	3 □ Widowed 4 🗓 Divorced	Year or Dates: 1967	-68						Specify: Whi	
<u>7</u>	nati	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Deced	dent's Usual Occ kind of work dor DO NOT use reti	upation ne during mos	st of worki	ng	16b. I	Kind of Business/Ir	ndustry
2	withir ene. than	d mc	Elementary/Secondary (0-12)	College (1-4or 5+)	Plumbe		700)			P1u	mbing	
0 0	Hygie other	Ö	17. Father's Name (First, Middle, Last)		1		18. Moth	er's Name	(First, Middle	, Maide	n Sumame)	
au	id be ental ked c	To Be	 Willie William And	erson			Ethe1	l Vir	ginia	Bail	ey	
Maryland 21215-0036	shou and M mar umat	-	19a. Informant's Name/Relationship (T		19b. Mailir	ng Address (Stre					or Town, State, Zi	p Code)
	and 2 eelth a 127 i		Christopher Lee An) Leyte				A 92	2118	
ore	of He		20a. Method of Disposition 1 Burial 2 Cremation 3 1	20b.	Place of Dispo cemetery, crer	sition (Name of natory or other p	lace)	Janua	ate 7,		Location - City or T	
Ĕ	Pag ment ant: lary o		4 □ Donation 5 □ Other (Specify,) Che		e Crema		200			tsville,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amortant: in litem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic avent, the Medical Examinar must be notified at one.	000000000000000000000000000000000000000	21. Signature of Funeral Service Licens 200 Licens	ente Mo)1251 B	Name and Add oing Ho everly	me Crei L. Hec	matic krott	n Serv	ice C. C.	P.O. Bo larksvill	x 784 e, MD 21029
			23a. Part1. Enter the dispase, or comp shock, or heart fallure. List only of	lications that caused the dea one cause on each line.	th. Do not ent	er the mode of d	ying, such as	cardiac o	r respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. DZINOLAZI	1'n cma	.F hun	2 2	Jus 1	TIL			3yr1.
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):							
ш		-G	Sequentially list conditions,	b. Due to (or as a conse	quanea of):							
	nsit	m L	cause. Enter Underlying									
<u>_</u>	exection and items	Examiner	that initiated events resulting in death) Last	Due to (or as a conse	quence of):							
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9	ng ph	Med	IF FEMALE:				_				1	
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o o	the e	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	death 5	Other (specify)						
	thet ti ed by detac	P.	Part II. Other significant conditions co	entributing to death but not re	sulting in the u	nderlying cause	given in Part I	l.	23e. Did	tobacco	use contribute to	the cause of death?
ds,	uires the signed id be dei	d by	Animia, E	ubylsin					10	Yes 2	2□No 3□Pro	bably 4 Unknown
Ö	w requires been site should I	lete							24a. Wa		24b. Were aut	opsy findings available ompletion of cause of
Be	fhe ia te has age 2	Completed							auto perf	opsy omed? 2⊠N	death?	ompletion of cause of 2 No
<u>ta</u>	un: '	Bec	25. Was case referred to medical				26. Place	e of Death	(Check only		· · · · · · · · · · · · · · · · · · ·	
>	nysic nis ce direc	10 E	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatient 2	ER/Outpatier	IL 3 LI DOA	A THE RESIDENCE OF THE PARTY OF THE	ursing Hor	ne 5X∏Res	idence	6 ☐Other (Speci	fy)
0	ng Pi		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	V			28d. Describe	how inji	ury occurred	
<u>s</u>	Attending Physician: sr death. ector: After this certifice by the funeral director, I	catl	2 Accident investigation 3 Suicide 6 Could not be	OC Diversities And			☐ Yes 2☐		194 Lagation	/Ctrant a	and Alembar or Dur	al Pauta Numbar
Division of Vital Records,	or Attand after death Director: /	Certification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec		eet, ractory, onto	e		City or To	wn, Sta	ind Number or Rur te)	ar House Number,
_	Hospite 24 hours Funeral	Medical C		/sician. To the best of my kiner: On the basis of examin								
	within 7 to the To the comple	Me	29b. Signature and title of certifier	1)		29c. Lice	nse number			29d. D.	ate signed (Month,	Day, Year)
	->-0		Dan 12. M	MD.		0	305	17		Janu	ary 6, 20	006
1	00		30. Name and address of person who o	completed cause of death (Ite		Print) D.L	L	Perl	22.	0,1	face last	MD JOY
6	Sta	ite	31. Date filed (Month, Day, Year)	32. Redistrar's Sign	W1	1-K- 150	CALM	, vive		00	UWKIG	701.00
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			For State Registrar	State of M	arylan		artmen rtificat			and M	_	gienę Reg. Nő.	HUD	01377
	Physici	an	Decedent's Name (First, Middle, Las								2. Date of De. Month	Day		3. Time of Death
	/Medic	al -	BIENVENIDO 4a. Facility Name (If not institution, give			MARES	4b. City,	Town, or	Location of	of Death	JAN	2 4c.	2006 County of Dea	4:25
	Examin	ier	NATIONAL NAVAL				,		IESDA				MONTGO	
	Funeral		Social Security Number 6. Security Number			last birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birt	th v. Year)	0.0:	abolose (Ctransconficient)
8	Director		300 00 4007	M 2□F	78	Yrs.	Morning	Dayo	1,00.0		June 2,	1927		Philippines
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Many Heth	ţō	Maryland Prince Ge	orge's	F	t. Washi	ington							1 ☐ Yes 2√√No
	h the	irec	10e. Street and Number		1		10f. Zip					10g. Citi	zen of What C	ountry?
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23s or 28s-f show other traumatic event, the Maricell Eracular minimalisal at a chilled at	Funeral Director	126 ElCamino Way					744					USA	
	teme	nuel	11. Marital Status	12. Was Decedent Armed Forces	?	.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cuba	ispanic Ori n, Mexicar	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	•	 Race - Ame Black, Whi 	
36	rs afte	by F	1 ☐ Never Married 3 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ₩ Yes 2 ☐ If Yes, Give Year or Dates:	194	6-	1 🗆 Yes	2√XNo	Specify:				Specify: F	ilipino
8	2 hou		15. Decedent's Ed	ucation	196/	16a. Dece	dent's Usu	al Occupa	ation			16b. Ki	nd of Business	/Industry
215	within 7; ene. then "n	ple	(Specify only highest gra- Elementary/Secondary (0-12)	de completed) College (1-4or	5+)	life.	DO NOT u	se retired	du <i>ring</i> mos ()	t or work	ng			
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and	uld be fif fental H rked oth tic even	Be	17. Father's Name (First, Middle, Last)								(First, Middle,		Sumame)	
Maryland 21215-0036	should be ind Mental is marked umatic ev	၉	Sebastian Alamares 19a. Informant's Name/Relationship (7)			19b. Mailie	na Address	(Street a			a San Jua al Route Numbe		r Town, State,	Zip Code)
∑	and 2 s ealth an m 27 is:		Filomena P. Alamares				•				ton, Mar			
d)	s 1 ar		20a. Method of Disposition			Place of Dispo	sition (Nar	ne of		the same of the same of	Date		cation - City or	Town, State
Ë	Page nent o int; if iry or		Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			ington N				an. 9	, 2006	Arli	ngton, V	irginia
Baltimore,	permit. Pages 'Department of H Important; If Ite any Injury or of		21. Signature of Funeral Service Licen	Swan	\sim	22			s of Facilit	GE	orge P. K kon Hill,			Home PA 0745
			23a, Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cause	d the deat	h. Do not ent								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			ARTER	Y DIS	EASE						Onset and Death
1 學	/Medical Examiner		resulting in death)	Due to (or as										
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	nsit	Examiner	Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury			,								
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8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Icai	· ·	. d.										
Õ	artifica ing ph e as th	e	IF FEMALE:							,				
Вох	death certifica attending ph of for use as the	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	ıldeath 3[Ectopic p						23d. Date of de Month	livery Day Year
P.O.	at the de by the a tached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	it time or d	eath 5L	⊒ Otuei (st	Decity)						
	that the	by Ph	Part II. Other significant conditions c	ontributing to death	but not res	ulting in the u	nderlying o	cause give	en in Part I		23e. Did t	obacco u	use contribute t	o the cause of death?
Records,	w requires been sign should be										10	Yes 2	ŇNo 3□P	robably 4 Unknown
တ္တ	aw re	piet									24a. Was		24b. Were a	utopsy findings available completion of cause of
æ	The ete h page	Completed									perfo	rmed? 2 X No	death?	s 2□ No
Vital	ilcian: certific rector.	Be (25. Was case referred to medical examiner?					100			(Check only o			
o	this aldi	2	1 ☐ Yes 2 📉 No 27. Manner of Death			ER/Outpatier		OA OUN	er: 4 □ Nu		me 5 Resident			ecify)
U C	After Une	ion	1 XNatural 5 ☐ Pending	28a. Date of Inj (Month, D	ay Year)	Injury	" _M	28c. Injun Worl	k? Yes 2 🗍		26d. Describe i	now injur	y occurred	
Division	Atten deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Ir			reet, factor							ural Route Number,
Ω	al or safter	Certification:	4 Homicide	building, e	itc. (Specif	(y)					City or To	wn, State	·)	
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in the Funeral C	Medicai (ysician: To the bes niner: On the basis and manner s	of examina									
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1			29	c. Licens	e number				te signed (Mon	-
			Sundsan E	Jones -	UD				12367					4,2006
D	(6)		30. Name and address of person who	completed cause of	death (Iter	п 23а) (Туре,	Print)				VAL MÉI			R
			LINDSAY E. JONES	LT MC	USN	atura 🎜		BE	THESI)A MI	20889-	-5600)	
State 31. Date filed (Month, Day, Year) Registrar JAN 0 5 2006 Registrar's Signature														

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** JANUARY 9:20 A. 18, 2006 JAMES LOUIS BENTZ, SR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **EMMITSBURG** FREDERICK 15905 OLD FREDERICK RD. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) AUG. 22, 1925 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours 1(XM 2□ F Yrs. Director 80 EMMITSBURG, MD. 217-28-5839 Usual Residence of Decedent it. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ritment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23s or 28e-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director FREDERICK **EMMITSBURG** MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21727 15905 OLD FREDERICK RD. U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE If Yes, Give Year or Dates: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRODUCE FARMING 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JACOB BENTZ EDITH KRUGS 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTHONY BENTZ/GRANDSON 15905 OLD FREDERICK RD., EMMITSBURG, MD. 21727 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State perr it. Pages Department of Important: if it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) EMMITSBURG MEMORIAL 1/21/2006 EMMITSBURG, MD. 21727 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SKILES FUNERAL HOME An 210 W. MAIN ST., EMMITSBURG, MD. 21/2/-042/ Approximate Interval Between Onset and Death 23a. Pair. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, since the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so that the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so that the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so that the death is the death of the death. Imm to te Cause (Final diseas or condition RENAL FAILURE **Physician** 2 YEARS diseas or condition resulting in death) /Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DECENERATIVE 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2X No To the Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient TOP Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 X No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred . 27. Manner of Death Certification; Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD036168E JANUARY 19, 2006 oze who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 4910 A. Fairfield Rd. Fairfield JAN 9. egistrar's Signature _ State Registrar

			_ FUI	artment of Health and Mental Hyg	giene 006 01379
3	e e		Decedent's Name (First, Middle, Last)	2. Date of Dea Month	
	Physicia Medic	_	John Louis Becker	January	09 2006 0645 ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Mt. Airy	4c. County of Death
		X ₀	4328 Ridge Road Tr. 13 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs 8 Date of Birth	Carroll 9. Birthplace (State or Foreign
	Funeral Director		210-28-8243 1™ 2□ F 73 Yrs.	Months Days Hours Min. (Month, Day July 24	(Year) Country
	ס		Usual Residence of Decedent		
	arylar ehow	2	10a. State 10b. County 10c. City, Town or L		10d. Inside City Limits 1 ☐ Yes 2 ☐ Xo
	the M	ecto	MD Mt. A-		10g. Citizen of What Country?
	3a or	Funeral Director	4328 Ridge Road Tr. 13	21771	USA
	death	nera	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
9	or Ite		1 Never Married 2 Married 1 Yes 2 No 1952	1 ☐ Yes 2 ☐ Specify:	Specify: White
21215-0036	72 hours after death with the Maryland naturel', or Items 23a or 28a-f ehow disal Frantingt must be notified at	d by	3 Widowed 4 Divorced Year or Dates: 1955	edent's Usual Occupation	16b. Kind of Business/Industry
5	in 72 n na n na	olete	(Specify only highest grade completed) (Give	e kind of work done during most of working DO NOT use retired)	Tob. All di Businessingustry
212	d within giene. or then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Machinist	Worthington Pump Co
pu	be filed ital Hygi d other event.	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	Maiden Sumame)
yla	2 should to and Ment Is marked	2	Allen E. Becker	Helen Feeser	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other then *naturet', or items 23a or 28a-f show other treumatic event, it.a Medical Exertical must be notified at		E Company	ling Address (Street and Number or Rural Route Numbe	1 may 1 m
	s 1 and 2 of Health a item 27 ls other trei		Julia Becker/wife 4328 20a. Method of Disposition 20b. Place of Disp	Ridge Road Tr. 13 Mt. I position (Name of place) 01/11 ay 2006	20c. Location - City or Town, State
nor	Pages nent of int: If it iry or o			ner Miller Cemetery	Westminster, MD
Baltimore,	그 된 원 층 .		(1)	Pritts funeral Home and C	Thansa D A
ä	permi Depa Impo eny ir		4 E. Churt	412 Washington Road West	
Acer			23a, Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac or respiratory an	Interval Between
	Physician		Immediate Cause (Final disease or condition	unschm disesse	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):		
- 39"		P	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events c.		
ó	be executed sicien and burial-transit		resulting in death) Last C. Due to (or as a consequence of):		
8760,	cate be executed shysicien and the burial-transit	Physician/Medical	d		
9	entifica ling pl	Med	IF FEMALE:		
Вох	eath certific attending p I for use as I	lan	in the past 12 months?	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
o.	at the de by the (nysk	1 U Yes 2 No 9 Unknown	- Outer (specify)	
٥.	g g g	by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did to	acco use contribute to the cause of death?
of Vital Records,	w requires been sign should be		Kathe Valvolow duese, d	where II,	es 2 No 3 Probably 4 Unknown
eco	law requ as been 2 shoul	Completed	cenebrouscolor dury	24a. Wasa autop	
Ä		Com	,	perfor	med? death? 2☑No 1☐Yes 2☐No
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only of	ne)
of	Phye this al dii	. To	1 Yes 2 (IDNo) Hospital: 1 Inpatient 2 ER/Outpatie 2 ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time	ence 6 Other (Specify) ow injury occurred	
on	Jing After fune	tlon	1 Thatural 5 Pending (Month, Day Year) Injury 2 Accident investigation		on injury seconds
Division	Attending ir death. ector: After by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, s	street, factory, office 28f. Location (S City or Tow	treet and Number or Rural Route Number,
ā	s atte	Cert	4 Homicide Stemmed building, etc. (Specify)	Chy di Tow	n, State)
	Hospit 4 hour Funer ety fill	edical	29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in		
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Med	29b. Signature and title of certifier		29d. Date signed (Month, Day, Year)
	T W T G		1 / / / M MM	D2259G	01-10-2006.
	11504		30. Name and addless of person who completed cause of death (Item 23a) (Type	a, Print)	0 10 2000.
	10,00		Philip Ruzbarsky, MD 125 Airport D		1157
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		
100	Regist	rar	JAN 1 0 2008 Marie &	Grant,	

		•	1 - For Stete 1-5-06 Registrer Amend#'s10e.1	State of Marylan 96.Per FH PCC cr		artment of <i>tificate o</i>			en@ () () 6 g. No.	01380
*	Physici	an	Decedent's Name (First, Middle, Last					2. Date of Death Month	Day Year	3. Time of Death
)	/Medic	al	Robert Eugene B 4a. Facility Name (If not institution, give			4b City Town	n, or Location of Deat	Jan. 1,	2006 4c. County of Dea	6:53 p ^M
	Examin	ei	Prince George's		er		erly			George's
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.		If Under 1 Ye Months Day	ar ff Under 24 Hrs			rthplace (State or Foreign ountry)
	Director		3/9-/2-0090	⊠ ^{M 2□F} 52	Yrs.	Wichtins Day	73 Flours Will.	Mar 25,		shington, DC
	land		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Many Many	to	Maryland Prince G	eorge's	Bowie					1X Yes 2 □ No
	or 28a	irec	10e. Street and Number Allengle	en Court		10f. Zip Cod	9	10	g. Citizen of What C	ountry?
	death with the Maryland ms 23a or 28a-f ehow	aiD	16100 Glenn Alle				20716		USA	
2-0030	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 is marked other than "netural", or Items 23a or 28a-f show other traumatic event, the Mardical Exercities main the notified at	by Funeral Director	11. Marital Status 1 Never Married 2区 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify C 1 ☐ Yes 2121 h	of Hispanic Origin? (Suban, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:	erican Indian, ite, etc. Black
ဂ ဂ	72 hc	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usuaf Oci kind of work do	ne durina most of wo	orking 1	6b. Kind of Busines:	s/Industry
V	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. i	DO NOT use ret	ired)		. = = =	
7	al Hygie f other i		17. Father's Name (First, Middle, Last)	4	Sa1	es	18. Mother's Na	me (First, Middle, M	AT&T aiden Surname)	
yland	Mental Mental rked c	To Be	Robert Eugene Bus	bу			Margar	et Ethel I	Ouncan	
Mary	2 should be in and Mental I is marked or raumatic eve		19a. Informant's Name/Relationship (7	**	19b. Mailir	ng Address Str	ergien Court	ural Route Number,	City or Town, State,	Zip Code)
	1 and 2 Health tem 27 l		Verla J. Sutton-B	-	101	OO OICH	n Allen C	DOW.	re, rib zo	7/10
Baltimore,	iges 1 it of H if Ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	emetery, crei	sition (Name of natory or other)			0c. Location - City o	
Ш	permit. Pages I Department of H Important: If Ite eny Injury or ot once.		4 Donation 5 Other (Specify 21. Sign uneraf Service Licen				EMETERY 1 / 7 / dress of Facility G			Maryland
n	Deporting of the control of the cont		1/1/2/4	MO1343			imore Ave			20781
		П	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the deat	h. Do not ent	er the mode of	tying, such as cardia	c or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Finaf disease or condition	a Ischemic/no	nische	mic dil	ated card	iomyopathy	7	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):				<u> </u>	
		<u></u>	Sequentially list conditions, if any, leading to immediate	b. Three vesse		nary ar	tery dise	ase		
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	Electrolyte		ance				
o Î	an an		resulting in death) Last	Due to (or as a conseq						
58/60 ,	ificate be executed g physician and as the burial-transit	edicai	•	d. Renal insuf	ficien	су				
POX P	— Co.ei		IF FEMALE: 23b. Was decedent pregnant	23c. ff yes, outcome of pregna					23d. Date of de	alivery
oj.	requires that the death certifit een signed by the attending I nould be detached for use as	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown		Ectopic pregna Other (specify)			Month	Day Year
νς Σ	igned be deta	by P	Part fl. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause	given in Part I.	23e. Did toba	acco use contribute	to the cause of death?
Vital Records,	w require been signature	ted	Diabetes, Hypert	ension, Hyperl	ipidem	ia, Gou	t	1 🗆 Yes	2 2 No 3 □ F	robably 4 Unknown
ပို		Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
I E	: The cate ha	Con						perform 1 ☐ Yes 2	ed? death? SNo 1 ☐ Ye	s 2 No
<u> </u>	Physician: The law this certificate has I ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:				ath (Check only one		
0	Phy this rald	: To	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o	1t 3 □ DOA 28c. li	Other: 4 Nursing I	Home 5 Resider 28d. Describe how		ecify)
<u></u>	Attending I or death. ector: After by the funer	atio	1 XNatural 5 Pending 2 Accident investigation		Injury		Nork? □Yes 2□No			
Division of	2 2 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, offi	СӨ	28f. Location (Stre City or Town,	eet and Number or F State)	Bural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dircompletely filled in I	edicai	29a. Certifier 1⊠ Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deat ition and/or in	h occurred at the vestigation, in m	e time, date and place by opinion, death occ	e, and due to the car urred at the time, da	use(s) and manner a le and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	Desaid		29c. Lic	ense number		d. Date signed (Mor	th, Day, Year)
)			Mar W	MATINU			33485	7	13/06	
12	-15)		30. Name and address of person who Linda Sloan 1	completed cause of death (fter 450 Merchantil			Largo M	D 20785		
25	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature _		Largo, ru	20705		
1	Regist	rar	IAN a 5 ence	E A	has	RC A				

		•	For State Registrar	State of Maryland		rtment of H			ene g. kg. 000	5 0	1381
		78	Decedent's Name (First, Middle, Last)					2. Date of Death			3. Time of Death
	Physici		JOSEPH	В	OYKIN	S		Month JANUARY		ear 6	4:30P M
)	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Deat		4c. County of		
	Examin	iÇi	1212 SHADY GLEN D			FOR	ESTVILLE		PRIN	CE GE	ORGES
25	Funeral		5. Social Security Number 6. Sex		birthday)_	If Under 1 Year	If Under 24 Hrs	8. Date of Birth			e (State or Foreign
	Director		579 12 1608 XX	M 2□F 83	Yrs.	Months Days	Hours Min.	OCT. 12,	1922	(Country NORTH	CAROLINA
			Usual Residence of Decedent					1001. 11,			OMMODIA
	yland		10a. State 10b. County	10c. City, T	own or Loc	ation					Inside City Limits
	Mar F. at	to	MD PRINCE G	EORGES FOR	ESTVI	LLE					XXYes 2 □ No
	r 288	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	at Country	?
	3g. o		1212 SHADY GLEN D	RIVE			20747		UNITED	STAT	ES
	filed within 72 hours after death with the Maryland Hygiene. uther then "netural", or tems 23s or 28s-f ehow uther then "netural", or tems russt be recitied at	Funeral		2. Was Decedent Ever in U.S.	13. W	as Decedent of Hi	spanic Origin? (S	pecify Yes or No-	14. Race -	American	Indian,
LO.	r Ite		1 Never Married XX Married	Armed Forces? XXYes 2 ☐ No If Yes, Give		Yes, specify Cubai		to Hican, etc.)		White, etc.	
ğ	urs a	by	3 Widowed 4 Divorced	It Yes, Give Year or Dates:	1	☐ Yes XX No	Specify:		Specify:	BLAC	K
9	2 ho	Completed	15. Decedent's Educ		6a. Decede	ent's Usual Occupa	ition	rking 1	6b. Kind of Busi	ness/Indus	try
215	hin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired,)	iking			
2	d wit	on	12TH		AF CI	VIL SERV	ANT		EPARTME	NT OF	DEFENSE
פַ	othe vant,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, M	laiden Sumame)		
ā	ald by fenta rked rice	To E	JOHN BOYKINS				ROSHA	BAILEY			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: If item 27 is marked other than "netural", or Items 23s or 28s-f ahow any injury or other traumatic evant. The Medical Evantment be netitied at once.	Γ.	19a. Informant's Name/Relationship (Type	oe, Print)	9b. Mailing	Address (Street a		ural Route Number,	City or Town, St	ate, Zip Co	de)
	nd 2 alth a 27 is		MILDRED BOYKINS /	WIFE	1212	SHADY G	LEN DR.	FORESTVI	LLE, MD	2074	7
Baltimore,	s 1 a f Hez itam othe		20a. Method of Disposition	dom.	of Dispos	ition (Name of atory or other place	a)		Oc. Location - C		
D D	age ant o it: If y or		XX Burial 2 □ Cremation 3 □R 4 □ Donation 5 □ Other (Specify)	emoval from State		JETERANS	' 1	00/2005	CHELTEN	TUAM	MD
莹	artme ortar injur		21. Signature of Funeral Service License								
Ba	permi Depa Impo any is		PM	000		MARSHALL	'S FUNER	AL HOME C	F MARYL	AND, I	NC.
			23a. Part1 Enter the disease, or compli	cations that caused the death.				AD SUIT			4 h oproximate
			shock, or heart failure. List only or	ne cause on each line.		, and mode of dyna	9, 000, 00 00, 00	o or roopmatory arro		ln'	terval Between nset and Death
	Prysician		Immediate Cause (Final disease or condition resulting in death)	STROKE						-	
	/Medical Examiner		resulting in death)	Due to (or as a consequen	ce of):						
į,	LAUIIIIICI	L	Sequentially list conditions,	ADVANCED ALZH		'S DISEA	SE				
	ъ <u>;</u>	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequen	ce of):						
	acute ind trans	am	Cause (Disease or injury that initiated events resulting in death) Last	2.							
Ö,	e ex	<u> </u>	resulting in doutily East	Due to (or as a consequen	ice or):						
8760,	cate be executed physician and s the burial-transit	dical		d							
9	ng pl		IF FEMALE:								
Box	death certific e attending p id for use as	an/l	23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de		Ectopic pregnancy			23d. Date Monti		ıy Year
	0 0 2	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of deat 9☐Unknown	h 5□	Other (specify)			1910110	1 00	r oai
P.0	that the death od by the atte detached for	Physician/Me	9 Unknown								
S,	requires that the een signed by th hould be detache	by	Part II. Other significant conditions cor	ntributing to death but not resulting	ng in the ur	iderlying cause give	en in Part I.	23e. Did tob	acco use contrib	ute to the o	cause of death?
ğ	v require been się should b							1 ☐ Ye	s 2⊡No, 3	Probabl	ly XXUnknown
S	>	ompleted						24a. Was ar	24b. W	ere autopsy	findings available
Re	a - e	E C						autops	led? de	or to compl ath?] Yes 2[letion of cause of
Vital Record	iclan: Th certificate ector, pag	C	25. Was case referred to medical				26 Place of Do	1 ☐ Yes 2 ath (Check only one		1105 20	
⋝		O B	eyaminer?	lospital: 1 ☐ Inpatient 2 ☐ EP	/Outpation	t 3 DOA Othe		Home XX Reside		(Speciful	
of		I	27. Manner of Death	28a. Date of Injury 28	b. Time of	28c. Injun		28d. Describe ho			
on	ding I h. After funer	tior	XXNatural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □ No				
Division	I or Attending after death. Diractor: After	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home	e. farm. stre	eet factory office		28f. Location (Str	eet and Number	or Rural R	loute Number.
$\frac{2}{2}$	i Sir e	erti	4 Homicide determined	building, etc. (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town	, State)		
	Hospital A hours Funarel tely filled	O	29a, Certifier XIX Certifying Phys	sician: To the best of my knowle	edge death	occurred at the tin	ne date and place	e and due to the ca	use(s) and man	ner as state	ad .
	To the Hospital within 24 hours a To tha Funarel to completely filled	ledical		ner: On the basis of examination							
	thin 2 than than mple	Me	29b. Signature and title of certifier	000		29c. Licens	e number	25	d. Date signed	(Month, Da	v. Year)
	To Too	1		1 blan	5/						
•	(2)		/	00	/		4525		JANUARY	03,	2006
2	(10)		30. Name and address of person who co					11000 ===		007	
			S.J. RAO, M.D.			TCHELLVI	LLE RD.	#220 BC	WIE, MD	2071	б
	St Regist	ate trar	31. Date filed (Month, Day, Year) JAN 0 5 2006	2. Registrar's Signatur	Lan	1.5					
		-									

		4	For State Registrar	State of Mar	-	partment of F e <i>rtificate of</i>			giene	06	0 3	32
			Decedent's Name (First, Middle, Last))		7711110410 01		2. Date of Dea	ith		3. Time of	Death
	Physicia /Medic		Robert Leyton B	erger				Month	Day 6	Year 2006	9:20	A^{M}
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Dea	th	4c. Cour	nty of Death		
*			101 Jefferson St.			Berlin				orces		
	Funeral		5. Social Security Number 6. Se	XM 2DF	In yrs. last birthda Yrs.	Months Days	If Under 24 Hrs Hours Min	. (Month, Day	, Year)	9. Birth	place (State o intry)	
	Director	-	215-62-1416 Usual Residence of Decedent	5	3			9/19/1	952		NE)
	/land		10a. State 10b. County		10c. City, Town or	Location					10d. Inside Ci	ty Limits
	Man,	ţō	MD Worces	ter	Berlin						1 X Yes	2 🗌 No
	or 282	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cou	intry?	
	23a (aiD	101 Jefferson St.			218	11			USA		
	r dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		I. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		lace - Amer llack, White		
36	s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 No If Yes, Give	1070	1 ☐ Yes 2 ☐ No	Specify:		Spe	cify:	White	
21215-0036	72 hours after death with the Maryland Insturel; or Hems 23a or 28a-f show Jisal Exart actinust be collinal at		15. Decedent's Edu		1970	edent's Usual Occu	nation		16b. Kind of			
5	in 72	plet	(Specify only highest grad	le completed)	(Gir	re kind of work done DO NOT use retire	during most of wo	orking				
212	e filed within al Hygiene. I other than " vent, the Me.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ood Prep	arer		Re	staur	ant	
ם	be filed Ital Hygid od other event, I	Be C	17. Father's Name (First, Middle, Last)					me (First, Middle,	Maiden Sum	ame)		
<u>yla</u>	2 should be and Mental Is marked (eumatic ev	은	Robert Lewis Be	rger			Rhoda	Joann (Christi	anson		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. Item 27 Is marked other than "neturel", or Items 23s or 28s-1 show tiem 27 Is marked other than "neturel", or Items 23s or 28s-1 show other treumatic event, The MsIteal Examt artificial to colline 1 at	1 2	19a. Informant's Name/Relationship (T	•	1	iling Address (Street					ip Code)	
di.	1 and 2 Health a Bm 27 II		Robert L. Berge 20a. Method of Disposition	r (Father)	610	6 Jack Dr	., Salisl	oury, MI	2180 20c. Locatio	4 City or T	Town State	
Baltimore,	permit. Pages 1 Department of H Importent: If ite any injury or ot		1 ☐ Burial 2 又 Cremation 3 ☐		cemetery, c	ematory or other pla	1			95		
탪	iit. Partme artme orteni injury	- 1	4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License		Саре н	enlopen C 22. Name and Addre	rem. 1/9	7/2006	Fran	kford,	, DE	
Ba	permi Depa Impo any ir		Manualina	4 7 as	anta	108 Willi	am St.	ne burb	age r	unera	и поше	l.
	-		28a. Part1. Enter the disease, or composhock, or healt ailure. List only	lications that caused t	e geath. Do not e			ac or respiratory ar	rest,		Approximat Interval Bet	
G	Pnysician		Immediate Cause (Final disease or condition	ASC'							Onset and I	Death
	/Medical		resulting in death)	α	consequence of):						Few y	ears
Н	Examiner		Sequentially list conditions	b								
	sit s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):							
	and and I-tran	Examine	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					-		
60,	be executed siclen and burial-transit	a E										
68760,	tificate be executed g physicien and as the buriat-transi	edicai		d								
Вох			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o					23d.	Date of deli	very	
	0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at ti		B □Ectopic pregnand D □ Other (specify) _	;y 			Month	Day '	Year
P.0	at the de by the tached	hys	9 🗆 Unknown	9□ Unknown								
Ś	The law requires that the ste has been signed by the bage 2 should be detache	by	Part II. Other significant conditions of	entributing to death but	not resulting in the	underlying cause go	ven in Part I.		_		the cause of c	
Record	w requir been si should	ted						101	/es 2□No	3 Pro	obabły 4 🔀	Jiknown
ec	as b	Completed						24a. Was autop		prior to c	topsy findings completion of c	available ause of
E H		Cor							2 X No	death?	2 🗆 No	
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			A	eath (Check only o				
of	Phys rthis ral dir	To :	1X Yes 2 □ No 27. Manner of Death	1 ☐ Inpatien 28a. Date of Injury	28b. Time	IBIN 30 DOA	4 Nursing	Home Resident			ofy)	
O	ding I th. : After funer	ţi	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Injur	y Wo	ork?]Yes 2. □No					
Division	or Attendiater death. I Director: A	iffica	3 ☐ Suicide 6 ☐ Could not be determined	200. Place of Injur	y - At home, farm,	street, factory, office		28f. Location (S City or Tox	Street and Nu	ımber or Ru	ral Route Num	nber,
Ö	s after s all Direct s all Direct s all Direct s all bire	Certification;	4 Homede	building, etc.	(Эрвспу)			City of Tol	vii, Siale)			
	Hospitel or Attending 24 hours after death. Funerel Director: After stely filled in by the fune			ysicien: To the best of								(2)
	To the Hospitel within 24 hours of To the Funerel Completely filled	Medical	one)	and manner stat	ed.							-7
	To To	2	29b. Signature and title of certifier	Helworth,	m 1	les.	Se number		29d. Date siç		i, Day, Year)	
			Joseph	1	111.01		0241		1- 7	- C		
1	17+1		30. Name and address of person who	HOLZ WOFT	4.0		NUIN ST.	SNOW !	1161	MA	2180	`₹
	St	ate	31 Date filed (Month Day Year)	32. Paristra				21.019	/	1000	2100	
700 300	Regist		31. Date filed (Month Day Year) 9 2	2006	a. K	Sneet ,						

			_ 101	-	artment of Health and M	ental Hygiene	00000			
			1 - State Registrar	Ce	ertificate of Death	Reg. No.				
1	Physicia		1. Decedent's Name (First, Middle, Last)	R	CO1110)	2. Date of Death Month Day	y Year 3. Time of Death			
	/Medic Examin		4a. Facility Name (If not institution, give si	reet and number)	4b. City, Town, or Location of Death	4c.	County of Death			
			409 Lynden	ALUCNUC Apt 103	PocomoKe	iu	Vorcester			
	Funeral Director		5. Social Security Number 6. Sex 10 20 7 144	M 2016 7. Age (In yrs. last birthday Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)			
			Usual Residence of Decedent	10.0		01-07-3	<u> </u>			
	f show	ō	10a. State 10b. County	10c. City, Town or L	1		10d. Inside City Limits 1 DYes 2 □ No			
	r 28a-f	Director	10e. Street and Number	ster Pocomi	10f. Zip Code	10g. Citi	izen of What Country?			
	23a o		409 Lynden A	Venue Apt. 103	21851		U.S. A.			
	ter des Items Instru	Funeral	11. Marital Status 1 1 Never Married 2 Married	2. Was Decedent Ever in U.S. 13. Armed Forces? 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.			
5-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show iteal Examinat mush be notitled at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: White			
15-0	be filed within 72 hours ital Hygiene. od other than "natural", event, the Medical Exc	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Giv	edent's Usual Occupation e kind of work done during most of working	16b. Ki	ind of Business/Industry			
2121	s within jiene. r than "	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	Re	staurant			
	be filed tal Hygie d other event, I	Bec	17. Father's Name (F)rst, Middle, Last)		18. Mother's Name	(First, Middle, Maiden	Sumame)			
Maryland	thould be id Mental marked o	P	Clyde B	rown	MYCH	le Co	lusey			
Ma	Ith an 27 is riting		19a. Informant's lame/Relationship (Type	Hirman 1750	ling Address (Street and Number or Rura)	d. Pocom	1 1 2 165			
ore,	ges 1 and 2 t of Health If item 27 I or other tre		20a. Method of Disposition 1 Burial 2 Cremation 3 Re	20b. Place of Disp	position (Name of Diameter place)		ocation - City or Town, State			
Baltimore,	Pa nen ant:		4 Donation 5 Other (Specify)	Delmar	Crematory 1-10.	-06 Del	mar md.			
Bal	permit. Departr Imports any inju		21 Signatur of pineral Service License		. 4 331		h funeral Home Lity, And. 21857			
1			23a. Part1. Enter the disease, or complic shock, of leart failure. List only on	ations that caused the death. Do not en	nter the mode of dying, such as cardiac or		Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	Multy	le Scherosi.	S	Onset and Death			
П	/Medical Examiner		resulting in death)	Due to (or as a consequence of).						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):	4 4 4					
	sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a onsequence of)	the Heat Failure					
8760,	cate be executed physician and the burial-transit	dlcal E		our to (til as a brisaquarica til)	hie Heart &	Pailure	,			
9			ILECTION C							
Вох	death certifi e attending ed for use as	lan/N	23b. Was decedent pregnant		□Ectopic pregnancy	1	23d. Date of delivery Month Day Year			
o.	0 0	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	4□Pregnant at time of death 5 9□Unknown	Other (specify)		,			
Δ.	The law requires that the ate has been signed by the page 2 should be detache	by Pr	Part II. Other significant conditions conf	inbuting to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?			
Vital Records,	w require been si		Chronic O	Di Die Du	I movery Disease	1 ☐ Yes 2	No 3 Probably 4 Unknown			
Rec	The law cate has b page 2 st	Completed	11 Ture	Visorder		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?			
ta	ician: Th certificate rector, pag	O	25. Was case eferred to medical	mia	26. Place of Death	1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No			
of Vi	8 0 1	To B	examiner?	ospital: 1 Inpatient 2 ER/Outpatie	Other	ne 5 Hesidence	6 □Other (Specify)			
		tlon:	27. Manner of Teath Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at 2 Work? M 1 ☐ Yes 2 ☐ No	8. Describe how injur	y occurred			
Division	al or Attandir s after death. al Director: Al ad in by the fu	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s		8f. Location (Street an	d Number or Rural Route Number,			
Ö	Ital or its afte ral Dir led in l		4 - Nothicide	building, etc. (Specify)		City or Town, State				
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one) Certifying Phys Certifying Phys Certifying Phys Certifying Phys Certifying Phys	ician: To the best of my knowledge, dea er: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	nd due to the cause(s) d at the time, date and	and manner as stated. I place, and due to the cause(s)			
	within To the comple	Me	29b. Signature and title of sertifier	non Family Proces	29c. License number	29d. Dat	te signed (Month, Day, Year)			
)			I Joh Duch	the wo	0005324	02	1-6-06			
t	1.1		30. Name and address of person who cor	npleted cause of death (Item 23a) (Type	Fred S. I	10× Pm	1-6-06 embe, no 21851			
	s Sta	ite	31. Date filed (Month, Day, Year)	32. Egistrar's Signature		-5 / 100	1001			
	Registr	ar	JAN 0 9 20	Ub Blown St. 19	DONEL .					

			Please Type or Print in Black in			•		
		_		artment of Health and Menta	II Hygiei	M2006 0138	3 L _i	
			1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg. e of Death			
	Physicia	ın	Victor Marcus Berger	Mo	nth	Day Year		
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	. 6, 2	006 11:50 Ac. County of Death	Alvi	
	Examin	er	Charlotte Hall Veterans' Home	Charlotte Hall		St. Mary's		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. 8, Date	e of Birth nth, Day, Ye	9. Birthplace (State or I	Foreign	
	Director		578-09-8312 11X № 2□F 85 Yrs.	Months Days Hours Min. (Mo	20,	1920 Washington	DC	
	pur »	1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L.	ocation		10d. Inside City	Limite	
	f sho	0				1 _ Yes 2		
	28a	Director	Maryland Charles Wald 10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?		
	within 72 hours after death with the Maryland ene. Than "natural", or items 23a or 28a-f ehow fre Madical Examinat mant be motified at		P. O. Box 182-Berry Road	20604		USA		
	deat	Funeral		Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican,	s or No-	14. Race - American Indian, Black, White, etc.		
36	or it	y Fu	1 Never Married 2 Married X Yes 2 No	1 ☐ Yes 2 🕅 No Specify:	5(0.)	Specify: White		
Š	hour:	ed by	3 Widowed 4 Divorced Year or Dates: WWII		1.40			
7	in 72 in 8 in 16	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation a kind of work done during most of working DO NOT use retired)	160	b. Kind of Business/Industry		
212	yiene.	mo.	Elementary/Secondary (0-12) College (1-4or 5+)	Plumber		US		
힏	al Hyg otha vant,	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name (First,	Middle, Maid			
<u>a</u>	Menta Menta arked	2	Ulysses Leonard Berger	lina H	eitmuller			
Maryland 21215-0036	2 short and Is m			ing Address (Street and Number or Rural Route				
e)	1 and Health am 27 thar t		Doris E. Berger - Wife 20a. Method of Disposition 20b. Place of Disp	. Box 182, Waldorf, MI				
סַר	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if than 27 is marked othar than "natural; or items 23a or 28a-f ehow any injury or othar traumatic evant, the Medical Examinating the inclined at once.		1 Burial 2 □ Cremation 3 □ Removal from State	matory or other place)		Location - City or Town, State		
Baltimore,	nit. Pa artme ortani injury		the state of the s	Memorial Gdns 1-11-200 2. Name and Address of Facility 30.	-			
Ba	Dep Imp any onc			30.		Washington Road MD 20601		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				180	
k	Pnysician		Immediate Cause (Final disease or condition	estivo Heart Rai	luno	Onset and De	ath	
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	gestive Heart fai.	-	,		
l.	Lammer	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	brillation _				
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Ć,	e be executed rsician and e burial-transit	Examiner	that initiated events c c					
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Вох	ath ce ttendi	an/I	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy		23d. Date of delivery Month Day Ye.	,	
о <u>.</u>	that the death led by the atter detached for u	Physiclan/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 5 ☐	Other (specify)		World Day 16	aı	
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00	w requires been si	Completed		24	a. Was an	24b. Were autopsy findings av prior to completion of cau	ailable	
Be	The lay te has age 2	mo		15	autopsy performed Yes 2	death?	se of	
ita		Be C	25. Was case referred to edical examiner?	26. Place of Death (Chec		12.160 22.110		
4-	Phyaiclan: The I this certificate ha	2	1 ☐ Yes 2 €No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		Residence	e 6 Other (Specify)		
on c	ling P	ino ii	27. Manne i Death 1	Work?	scribe how i	njury occurred		
Division	Attanding in death. actor: After by the funer	lcat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, si	M 1 Yes 2 No	eation (Stree	t and Number or Rural Route Numbe	ar.	
ο̈́	after after Dira	Certification:	4 Homicide determined building, etc. (Specify)	Cit.	y or Town, S	tate)	",	
	bours hours unera y fille		29a. Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, and due	to the cause	e(s) and manner as stated.		
	the Ho in 24 the Fu	ledical	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred at th	e time, date	and place, and due to the cause(s)		
	To the Hospital or Attanding Pl within 24 hours after death. To the Funeral Diractor: After it completely filled in by the funeral	2	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)		
0			AMMON F MD	D0060120		1/6/00		
Jr.	R + 11		30. Name and address of person who completed cause of death (Item 23a) (Type A. Wael Hasethma, D. 160 Hese	oital Rd Prince Fi	rede	rick, mo zoc	678	
4	Sta	ite	31. Date filed (Month, Day, Year) 32. Redistrar's Signature	print) Quit all the lime, date and place, and due investigation, in my opinion, death occurred at the lime and				
	Regist	ar	JAN U 9 ZUUD JOSEPHE JA.	Corre				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 3:00a M 9, Leonard Preston Boyles Jan 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sudlersville Oueen Anne's 431 Higman Mill Road If Under 1 Year | If Under 24 Hrs. 6. Sex 1 AM 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 64 Yrs. Director 214-42-9571 12/30/1941 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturat", or items 23a or 28a-f show any injury or other traumatic event, Ira Madical Examiner must be incitified an once. 1 ☐ Yes 2 No Directo MD Queen Anne's Sudlersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 431 Higman Mill Road 21668 USA by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 No Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Agriculture</u> Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Howard Wesley Boyles Mary Catherine Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 431 Higman Mill RD Sudlersville, MD 21668 Mary A. Boyles/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Sudlersville Cem. 01/12/2006 Sudlersville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home
370 W Cypress St Millington, MD 21651 21. Signature of Funeral Service Licensee 23a. Pmt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) oncress with Pnysician deno carama /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to infinishing cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to (or as a nonsequence of) Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical the as sete has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes Division of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No the 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1/10/06 70 In D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Washing K03340 516 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] [Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Bernard Joseph Baumgartner 12:55 PM January 1, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F 215-74-8926 88 Yrs. Director Nov. 25, 1917 Pennsylvania Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental hygiene.
ant: If Item 27 is marked other than "natural", or Items 23s or 28s-f show ury or other treumatic event, the Medical Example mutit be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Maryland Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 Duke of Gloucester St. 21401 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Priest Catholic Church 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard Baumgartner Frances Reischmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fr. John Kingsbury/friend 109 Duke of Gloucester St., Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State permit. Pege Depertment of Important: If any Injury or once. 4 □ Donation 5 □ Other (Specify) St. Mary's Churchyard 1/6/2006 Annapolis, Maryland 21. Signature of mera Service License 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pneumonia disease or condition resulting in death) 1 week /Medical Due to (or as a consequence of): Examiner Chronic Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ettending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification: To Be Completed by 3 Probably 4 Unknown 1 ☐ Yes 2√2√No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 28b. Time of 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation XXNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0063641 January 1, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9723 Healthway Drive Berlin, Dr. Frank Guarnieri Atlantic General Hospital 21811 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

UN 0 5 2006

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 11

2006

32. Resistrar's Signature

Registrar

CANFIELD

JAN 0 9 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For State Registrar		epartment of Health and a Dertificate of Death	Mental Hygie Reg.	2000 01000				
Physic		1. Decedent's Name (First, Middle, Last)	annine Coniff		2. Date of Death Jan 11, 2	Day Year				
/Medi Examir		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Deat	h	4c. County of Death				
Funeral		Frostburg Village No. 5. Social Security Number 6. Sex	7. Age (In yrs. last birtho	Frostburg If Under 1 Year If Under 24 Hrs	8 Date of Birth	Allegany 9. Birthplace (State or Foreign				
Director		215-26-9993	^{M 2} √ F 76 Yr	s. Months Days Hours Min.	Jul 20, 19	29 ^{co} MD				
aryland show		10a. State 10b. County	10c. City, Town o			10d. Inside City Limits				
e Mar	ctor	MD Allegany	Cur	nberland		1X□Yes 2□No				
be filed within 72 hours after death with the Maryland tal Hygiene. Ided ther than "natural", or Items 23a or 28a-f show event, the Medical Examination routified at	Funeral Director	10e. Street and Number 800 Tampley Avenu	e	10f. Zip Code 21502	10g.	Citizen of What Country? USA				
er deatl Items 2	uner	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.				
ours aft	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: white				
in 72 h	Completed	15. Decedent's Educ (Specify only highest grade	completed) ((ecedent's Usual Occupation Give kind of work done during most of wo fe. DO NOT use retired)	rking 16b	. Kind of Business/Industry				
ad withi	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	ŕ	C 8	& P Telephone Co.				
2 should be filed within and Mental Hygiene. Is marked other than eumetic event, the M.	To Be (17. Father's Name (First, Middle, Last) Joseph B. Coniff			ne (First, Middle, Maid Hart Conifi					
and 2 should eath and Men m 27 Is marke	ľ	19a. Informant's Name/Relationship (Type Edward Seward	nephew-in- ^{19b. N}	Mailing Address (Street and Number or Ru 6 Windsor Road	ral Route Number, Ci Cumberl	ty or Town, State, Zip Code) and MD 21502				
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tre		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 1 ☑ Donation 5 ☐ Other (Specify)	cemetery	isposition (Name of crematory or other place) Cemetery		. Location - City or Town, State umberland MD				
permit. F Departme Importar any injur		21. Signature of Funeral Service License		22. Narscarpellis Funeral H	ome, PA					
		23a. Part. Enter the disease, or complice shock, of heart failure. List only on	ations that caused he death. Do not	108 Virginia Avenue enter the mode of dying, such as cardiac		Approximate				
Physician		Immediate Cause (Final disease or condition	CONGESTIVE			Interval Between Onset and Death				
/Medical Examiner		resulting in death)	Due to (or as a consequence of)			77 10W3 3 /				
D ≅	ner	fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of)	:						
sxecute n and al-trans	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence of)	:						
tificate be executed physician and as the burial-transit	edical	L _d								
certifica ding pl		IF FEMALE:	c. If yes, outcome of pregnancy			23d. Date of delivery				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	in the past 12 months? 1 ☐ Yes 2 ☑ No 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							
that the ned by detac		Part II. Other significant conditions con	ributing to death but not resulting in th	ne underlying cause given in Part I.	23e. Did tobaco	to use contribute to the cause of death?				
equires een sign ould be	ted by	CHRUNIC OB	BTRUCTIVE CUN	US DIREAGE	1 🗆 Yes	2 No 3 Probably 4 Unknown				
ne fawr has be ge 2 sh	Completed				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?				
vician: Th certificate rector, pag	e Co	25. Was case referred to medical		OC Please of Dec	1□ Yes 2□					
nysicia nis cert direct	To B	examiner?	ospital: 1 Inpatient 2 ER/Outp	Othor	th (Check only one) ome 5 ☐ Residence	6 ☐Other (Specify)				
ding Phys		27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28b. Tim	ry Work?	28d. Describe how in	njury occurred				
Attence death ector:	Certification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm	M 1 ☐ Yes 2 ☐ No	28f. Location (Street	and Number or Rural Route Number,				
urs afte			building, etc. (Specify)		City or Town, St					
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical	29a. Certifier 1	ician: To the best of my knowledge, c er: On the basis of examination and/c and manner stated.	death occurred at the time, date and place or investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)				
To th within To th comp	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)				
,		Asidhir	nolated cause of death //s co. : T	D24907	JA	NWARY 12, 200 6				
6		Harit S. Sidh	u MDi 925 Bi	Stop Walsh Rds (1)	mborton	4, mD 21502				
0.	ate	31. Date filed (Month, Day, Year)	32. Fegistrar's Signature			7				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10 /Medical ecifity Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Silver Spring Montgomery 10 -May 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, NOV • 27 9. Birthplece (State or Foreign Country) Maryland 5. Social Security Number 6. Sex . 1915 **Funeral** 1□M 2¬F 90 Director 218-07-2027 Usuel Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28s-f ahow Examiner must be notified at Yes 2 □ No Directo Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with U. S. A. 20905 Itama 23a 1222 Cavendish Drive Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Specify: Specify: White þ permit. Pages I and 2 sirvers. Pygiene.
Department of Health and Mental Hygiene.
Important: If team 27 is marked other than "natural", any injury or other traumatic event, the Medical Exponge. 3 ♥ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Minnie Spivak William Weinblatt 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1222 Cavendish Drive, Silver Spring, Maryland 20905 Pauline J. Robinson - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Wash. Hebrew Cong. Memorial Park 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 1/5/2006 Washington, D. C. ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Danzansky-Goldberg Memorial Chapels, Inc. 20852 1170 Rockville Pike, Rockville, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the dath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ALZHEIMERIS DISEASE Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy fo in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown been signed to should be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 HO Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Diffusing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗔 Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Menth, Day, Year) 29b. Signature and title of certifier 29c. License number 0 1009874 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARRAGUT AVE. KEUSINGTON, MD 20895 ROSENBAOM 720 3 31. Date filed (Month, Day, Year) State Registrar

		1 - For State Registrar	State of Maryland		rtment of He		Mental Hy	giene Reg. No.	06	01391	
		Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death	
Physic /Med		MILDRED ELIZABI	ETH CHESKY				Januar		2006	1:27 A M	
Exami		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Deat	h	4c. Cou	inty of Death		
		Holy Cross Hospit	:a1		Silver				ntgome	ry	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	ay, Year)	Coun		
Director		213.44.7930	M 281F 92	Yrs.			June 3	, 1913	Takor	na Park, MD	
and w		Usual Residence of Decedent 10a, State 10b, County	10c. City,	Town or Lo	cation				1	Od. Inside City Limits	
Aaryli Fsho	5	Maryland Montgome	rv Sil	ver S	oring					1⊠Yes 2□No	
the N	Director	10e. Street and Number	-7		10f. Zip Code			10g. Citizen	of What Coun	itry?	
with Sa or	ā	11706 Goodloe Road	A		20906						
iled within 72 hours after death with the Maryland Hygiene. Hygiene. Wher than "natural", or Items 23a or 28a-f show ont, the Medicul Exercit et must be notified at	Funerai		2. Was Decedent Ever in U.S.	13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (S	Specify Yes or No	U.S	Race - Americ		
after of the state	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No				to Hican, etc.)		Black, White,		
al', o	by	3 ⊠ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		I□Yes 2⊠ No	Specify:		Spi	ecity: Whi	Le	
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ag ight	Jq.	Elementary/Secondary (0-12)	College (1-4or 5+)	lite. L	OO NOT use retired)			11 C	Govern	mont	
led w ygier ygier tt, tru	S	12th		Ac	lministrat		me (First, Middle			ment	
be fill H od otl	Be	17. Father's Name (First, Middle, Last)	~					ilburn	name)		
y ic sould i Mer narke	2	Hezekiah Magrude		105 14-16-	og Address (Street a				um Ctata Zia	Codel	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, the Medical Examination than instantial and once.		19a. Informant's Name/Relationship (Typ	· .		nnon Cour						
C, I		George S. Chesky,			sition (Name of	r DIIIV	Date		on - City or To		
10 1 10 10 10 10 10 10 10 10 10 10 10 10	,	1 Burial 2 □ Cremation 3 □ Re	moval from State	netery, cren	natory or other place		5/2006		•		
Definition Permit. Pages Department of moortant: If Its Inty injury or o		'4 □Donation 5 □ Other (Specify)			Cemetery				r Spri	ng, mb	
Department of the partment of		21. Signature of Funeral Service License	" +		Name and Addres					200 20005	
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		23a. Part1. Enter the ill ease, or complic shock, or bean fail fre. List only one	cause on each line.	DO HOL BIN	er trie triode or dyring	g, such as cardia	c or respiratory c			Approximate Interval Between Onset and Death	
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vequires that the de been signed by the should be detached	by P	Part II. Other significant conditions cont	ributing to death but not result	ting in the u	nderlying cause give	n in Part I.	23e. Did	tobacco use	contribute to th	ne cause of death?	
quire quire an sig uld b							1 🗆	Yes 2⊠N	o 3 ☐ Prob	ably 4 Unknown	
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₽ 0 ← 0	ompieted						auto perf	ormed?	death?		
VICIAN: The sician: The certificate h	O	25. Was case referred to medical				26. Place of De	ath (Check only				
(9)	To B	examiner? 1 Tes 2 No	ospital: 1 🏝 Inpatient 2 🗆 El	R/Outpatier	nt 3□ DOA Othe	or: 4 🗌 Nursing I	Home 5 ☐ Res	idence 6	Other (Specifi	y)	
on or ding Phys h. After this funeral di	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injury Work	at	28d. Describe	how injury or	curred		
ath.	atic	2 Accident investigation				res 2 □ No					
LIVISION I or Attending after death. Director: Afte	Certificat	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office			(Street and N wn, State)	umber or Rura	I Route Number,	
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hour hour uner	cal		ician: To the basis of my knowner: O the basis of examination								
UIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	one)	an manner stated.								
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		· WO Y	~		D-006	02000		Januar	y 3, 20	700	
2		30. Name and address of person who cor	n leted cause of death (Item 2 1500 Forest G	23a) (Type,	Print)	er Shrin	o. Marv	land 2	0910		
		Sonia Wycht, 10,			The same of the sa	phram	-o,				
S Regis	tate trar	JAN 0 6 20	32 Registrar's Signatu	130	848						

			For State Registrar	State of Maryland / Department of Health and Mental Hygiene Certificate of Death										01392		
	- Division		1. Decedent's Name (First, Middl	e, Last)							2. Date of De	ath		3. Time of Death		
	Physici /Medio		Israel		C	ohen					Month January	Day Year 10		10:05a M		
	Examir		4a. Facility Name (If not institution		nber)	4b. City, Tov	vn, or L	ocation o	of Death		4c. Count	y of Death				
			3148 Gracefiel				Silve	r S	prin	ıg		Mont	gomer	у		
п	Funeral		5. Social Security Number	6. Sex 1 2 X M 2 ☐ F	7. Age (In yrs.	• • • • • • • • • • • • • • • • • • • •	If Under 1 Y Months D	ear ays	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	h v. Year)	9. Birth	place (State or Foreign		
	Director		579 22 6434 Usual Residence of Decedent		82	Yrs.						3, 1923		York		
	land		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits		
	Many if sh	ō	Maryland Mont								1 ☐ Yes 2★					
	the 28e	Director	10e. Street and Number	gomery	5	ilver S	10f. Zip Co	de				10g. Citizen of	What Cau			
	3e or		3148 Gracefield	Road				090	/.					nuy?		
	72 hours after death with the Maryland neturel', or items 23e or 28e-1 show disel Examiner must be notified at	Funeral	11. Marital Status	12. Was Dece	dent Ever in U		Was Decedent	of Hisc	panic Orio	gin? (Spec	city Yes or No	US	oA - Americ	can Indian		
ယ	after or ite		1 ☐ Never Married 2 🛣 Marr	Armed For	rces? 2 □ No WW		f Yes, specify	Cuban,	Mexican	, Puerto F	lican, etc.)		ck, White,			
ලි	ours a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	e ates:		I∐Yes 2∭X	No	Specify:			Specia	y: Wh:	ite		
21215-0036	72 ho	Completed	15. Deceden	t's Education st grade completed)		16a. Deced	lent's Usual O	ccupati	on	4 - 4		16b. Kind of B	lusiness/In	dustry		
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yla	Men arke	ို	Max Cohen						Soph	ie S	nith					
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 le marked other then "neturel", or items 23e or 28e-f show majory injury or other treumatic event, the Madical Examiner must be notified at anose.		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address (St	reet and	d Numbe	r or Rural	Route Numbe	r, City or Town	State, Zip	Code)		
	and ealth m 27		Anna A. Cohen	/ Wife		3148	Gracef	iel	d Ro	ad Si	lver S	nrino.	Marvl	Land 20904 own, State		
Baltimore,	P ite	:	20a. Method of Disposition 1 ☐ Purial 2 ☐ Cremation	3 □Removal from 5		Place of Dispo- cemetery, cren	sition (Name of natory or other	f place)		Da	ite	20c. Location	City or To	own, State		
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ä	Depart Import Import any inj		21. Signature of Funeral Service	Licensee		22	. Name and Ad	dress	of Facility	Hine	s Rina	ldi Fur	eral	Home		
_	207 2 2		toward	Nella	bu									MD 20904		
М			23a. Part1. Enter the disease, or shock of heart failure. List	complications that ca	aused the deal	th. Do not ente	er the mode of	dying,	such as	cardiac or	respiratory ar	rest,	Ī	Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	Chron	do Ive	phocyti	o Toul							Onset and Death		
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9	e as	0 1	IF FEMALE:													
9	that the death certific ed by the attending p detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outo 1☐Live bit	come of pregnanth 2 Feta		Ectopic pregna	ancy					23d. Date of delivery Month Day Year			
O. Box	the a	Sic	1 Yes 2 No	4☐Pregna 9☐Unkno	Other (specify		-			Month Day						
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S,	Se un o	by					derlying cause	given i	in Part I.					e cause of death?		
orc	w requir been si should I	ted	Metastatic Squa	amous Cell	Carcin	noma					1 🗆 Y	es 2 No	3 Proba	ably 4 🙀 Inknown		
Record	has b	Completed	Spinal Stenosis	, Diabete	s Mell:	itus					24a. Was a		Were autop	osy findings available		
	ate oge	Sol									perfor	med?	death?			
<u>ita</u>	Physicien: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?					2	6. Place	of Death (Check only or					
<u></u>	Physi this o	ျှ	1 ☐ Yes 2 🛣 No	Hospital: 1 □ In	patient 2 🗆	ER/Outpatient	3□ DOA	Other:	4 🗆 Nurs	sing Home	5 Resid	ence 6 Oth	er (Specify)		
Division of Vital	ife ne	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of (Month	f Injury I, <i>Day Year)</i>	28b. Time of Injury	28c. li	njury at Nork?				w injury occurr				
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Ž	el or Attending s after death. Il Director: After d in by the fune	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place	of Injury - At ho g, etc. (Specif	ome, farm, stre	et, factory, offi	сө		28	f. Location (Si City or Town	reet and Numb	er or Rural	Route Number,		
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	Hosp 4 hou Fune ely fii	ical	29a. Certifier 1 Certifying (Check only Amedical E	g Physician: To the te Examiner: On the base	oest of my kno	wiedge, death	occurred at the	time,	date and	place, an	d due to the c	ause(s) and ma	nner as sta	ated.		
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	Medical		and manne	er stated.					. occurred	at the tille, Q	are and place, a	01 BUD DITE	uie Cause(S)		
	To To	-	29b. Signature and title of certifier				29c. Lice	ense ni	ımber		2	9d. Date signed	(Month, E	Day, Year)		
	(0		- Vince	1			D24	1035	j			Ianuary	3. 2	006		
			30. Name and address of person v	who completed cause	of death (Item	n 23a) (Type, F						y		~~~		
			E. Machado, M.D	., 3110 G	racefie	eld Roa	d, Silv	er	Spri	ing,	Maryla:	nd 2090	4			
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			For	ricase		of Marylar	nd / Depa	artmen	t of H	ealth a		•			01393		
			Registrar	=			Ce	rtificate	e of L	Jeatn		2. Date of De.	Reg. No.	000	3. Time of Death		
	Physicia	an	1. Decedent's Name (Month	Day		10:00 a M		
a A	/Medic		4a. Facility Name (If n			ımber)		4b. City.	Town, or	Location of	of Death	Januar		2006 County of Dea			
	Examin	er	528 Ann Dr	_		,		4b. City, Town, or Location of Death Westminster						Carı	\sim 11		
6 .	Funeral		Social Security Nun	nber 6.	Sex	7. Age (In yrs.		If Under Months		If Under Hours		8. Date of Bird	th Veas	9. Bi	thplace (State or Foreign		
\$	Director		220-28-774	11	1 □ M 2 🕱 F	7	73 Yrs.	MONUTES	Days	riouis	FVII(1,	April Da	17"1	932	MD		
	pu s	-	Usual Residence of D 10a. State 1	ob. County		10c, Ci	ty, Town or Lo	cation							10d. Inside City Limits		
	Aarylk sho	0	MD	Carro	01.1		Westm		r				1 3 Yes				
	28a-	Director	10e. Street and Numb					10f. Zip					10g. Citizen of What Country?				
	3a or		57 Webste	r Stree	<u>+</u>				21	.157				USA			
	death	Funeral	11. Marital Status	or built	7	cedent Ever in U	J.S. 13.	13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					-	14. Race - Am Black, Whi			
9	or Ite		1 Never Married	_	1 ☐ Yes If Yes, G	2 X No ive		1 ☐ Yes		Specify:		, , , , , , ,		Specify: Wi			
21215-0036	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Itema 23a or 28a-f show ther, I'ra Medical Exartinat must be notified a	d by	3 ☐ Widowed 4		Year or I	Dates:		dent's Usua		tian							
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<u>Ja</u>	2 should be and Mental Is marked o	To Be	George Al	bert Le	eister,	Jr				Jeni	nie E	Bell Ri	11				
Maryland	s 1 and 2 should f Health and Men Itam 27 Is marke other traumatic		19a. Informant's Nam					•				I Route Numb			Zip Code)		
	and Sealth Im 27 har tr		Cathy Boll		daughtei		-	Ann D		-		ster, 1		21157	Town State		
Baltimore,	m O - 1		20a. Method of Dispos 1 XBurial 2 🗌	Cremation 3		State	Place of Dispo cemetery, cre			1	-	7/2006		cation - City o			
≣	permit. Page Department Important: If any injury or once.		4 ☐ Donation 5	-		Lei	sters	Churc 2. Name an					Wes	stminst	er, MD		
Ba	permi Depa Impo any i				1	~	173	~ + + - ~	- Elian	$-\infty$	Llomo	and C	hape.	L, P.A.	21157		
-1			23a. Part1. Enter the shock, or heart	disease, or cor	nplications that	caused the dea	th. Do not en	12 Water the mod	shin e of dying	g ton g, such as	Roac cardiac o	Westa or respiratory a	mins rrest,	ter, M	Approximate		
	Physician		IIIIIII Galate Cause (F)	failure. List ont nal	one cause on	each line.			o(-						Interval Between Onset and Death		
	/Medical		disease or condition resulting in death)		aDue to	(or as a consec	quence of):	Cer	770	1517							
	Examiner		Convention list cond	itions	bY	male	coholi	c 3	tea	tohe	Dorte	46					
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760,	ate be executed hysicien and he burial-transit	cai E	•			(0) 43 4 00/130	4401100 01).										
687	ficate phys s the				d												
	Attending Physicien: The law requires that the death certifica robath. cloath. ector: After this certificate has been signed by the attending phort the tuneral director, page 2 should be delached for use as it.	by Physician/Med	IF FEMALE: 23b. Was decedent p	regnant		utcome of pregn		75					2	23d. Date of de	livery		
.O. Box	death e atte	icia	in the past 12 m 1 □ Yes 2 ☑	onths?		birth 2 Feta		⊒Ectopic pr ⊒ Other (sp						Month Day Year			
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ord	requi	eted	Coren	n) a	ter 2 0	u seon						10			robably 4 Unknown		
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⋚	sicial certil recto	o Be	25. Was case referre examiner? 1 Tyes 2 Type		Hospital:	Inpatient 2	TER/Outpatio	nt 3 🗆 DC	Othe	26. Place	of Death	n (Check only o	danca (That /Sa	Pasidence		
o	g Phy er this eral d	n: To	27. Manner of Death		-	of Injury oth, Day Year)	28b. Time o		28c. Injury	/ at	arsing rioi	28d. Describe	how injur	y occurred	Residence		
0	ath. r: Aft	atio	1 ☑Natural 2 ☐ Accident	5 Pending investigati	on	min, Day 19ai)	Injury	М	Work	Yes 2	No						
Division of Vital Records,	l or Atte after de Directo s in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d 286. Plac	e of Injury - At h	nome, farm, st	reet, factor	y, office			28f. Location (Rural Route Number,		
	urs aff			/	į.												
	Hospital 24 hours Funeral etely filled	edicai	29a. Certifier 1 (Check only 2 one)	Certifying F	miner: On the	ne best of my kn basis of examin nner stated.	owledge, dea ation and/or in	th occurred evestigation	at the tim , in my o	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Mec	29b. Signature and til	tie of certifier	and ma	inioi stateu.		290	c. License	e number			29d. Dat	e signed (Mor	th, Day, Year)		
	. /		1	(/_				000	507	763		11	4/04			
	Mar		30. Name and address	s of person wh	o completed ca	use of death (Ite	m 23a) _, (Type		_		^	a, MD	- (1104			
	φ		686	C. Not	de Rd	UW	est m	unstan	er	Inc	<i>></i>	21157					
	Sta		31. Date filed (Month			Registrar's Sign											
2	Regist	ar		JAN U 5	ZUU5	Gloria	J.	Coast	2								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 0456 A M Myra Lois Daniels January 6, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner E1kton

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Union Hospital 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ KF 221-36-0345 Yrs. Director September 30,1949 Wilmington Usual Residence of Decedent DE with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location rthen "naturel", or Items 23e or 28a-f show the Medical Examinatinast be rediffed at 1 Yes 2 No Director Maryland Cecil **Elkton** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 St. Michael Court 21921 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 西No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white Specify: Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) chiropractor medical transcriptionist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked other any injury or other treumatic event 2008. Be Milton Furches ٥ Ann White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Catherine Court Bear, DE Milton Weaver (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Gracelawn Mem Park Jan.9,2006 New Castle, DE '4 □ Donation 5 □ Other (Specify) 21. Signature of Fun all Jenice Licens 22. Name and Address of Facility McCrery Funeral Homes, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician TSTHMA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physiclan/Medical Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 218 No 1 ☐ Yes 2 ☐ No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 X ER/Outpatient 3 □ DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. nours after death nerel Director: A filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number C1000,5656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William 32. Egistrar's Signature 31. Date filed (Month

DHMH 17 Rev 1/2001

State

Registrar

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			For State Registrar		aryland / De		nt of Hea	lth and M	1ental Hy		6 01395		
141	Physic		Decedent's Name (First, Middle HARRY	L.			WIC I	TD.	2. Date of De Month	ath	Year 3. Time of Death		
	/Medi Examir		4a. Facility Name (If not institution Peninsula legio	n, give street and number)	Contar		Town, or Loca	ation of Death	UI .	4c. County of	4c. County of Death Wico mico		
	Funeral Director		5. Social Security Number 217-30-7707		71 Yrs	Months		Juder 24 Hrs. Durs Min.	8. Date of Bir (Month, Da MAY 10	th v. Year)	9. Birthplace (State or Foreign Country) MARYLAND		
	hours after death with the Maryland tural', or itema 23a or 28a-f show al Examinar must be nutified at	i Director	Usual Residence of Decedent 10a. State	OMICO	10c. City, Town o	NSBURG 10f. Zip				10g. Citizen of Wh	•		
9036	72 hours atter death 'natural', or itema 2 oral Exeminer mul	d by Funeral	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	12. Was Decedent Amed Forces? 1 🖾 Yes 2 🗀 N If Yes, Give Year or Dates:	1953 - 1957		21XNo Sp		USA 14. Race- Black, Specify:	A - American Indian, , White, etc. WHITE			
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Maryland	should be filed nd Mental Hygi i marked other umatic event, I	To Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Mather's Name (First, Middle, Mather's Name) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Bural Boute Number, Company)) JIVINGSTON		
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Baltimore,	permit. Pag Department Important: I any injury o		4 □ Donation 5 □ Other (S 21. Signature of Emerge? Service	Lay Ha	WICOMIC	22. Name and 705 E	MAIN S	^{Facility} BOU TREET	NDS FUN SALISBU	NERAL HOM			
	Physician /Medical Examiner)r	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Onset and Di disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Due to (or as a consequence of):										
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	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical	(Check only 2 Medical one) 29b. Signature and the of centified	g Physician: To the best of Examiner: On the basis of and manner sta	examination and/o	r investigation,	at the time, da in my opinion License num	, death occurr	ed at the time, o	cause(s) and mann date and place, and 29d. Date signed (I	d due to the cause(s)		
•	200		30. Name and address of person	who completed cause of de	eath (Item 23a) (Tyl	pe Print)	D 46	536			,		
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Harry L. Davis 217-30-7077

			1 - For State Ragistrar	State of	Marylan		artment of H		d Mental Hy	giene Reg. No. 2006	01396
n de la companya de l	Physic /Medi		1. Decedent's Name (First, Middle, La $ m LEON$		INNIS			2. Date of Dea Month JANUAR	ath Day Year	3. Time of Death 5:14 AM M	
	Exami	ner	4a. Facility Name (If not institution, giv PRINCE GEORGE'S 5. Social Security Number 6. S	HOSPITAI		last hirthday)	4b. City, Town, or CHEVER If Under 1 Year			4c. County of Dec	EORGE'S
	, Funeral Director	2	578-60-4241 Usual Residence of Decedent	Š M 2□F	60	Yrs.	Months Days		8. Date of Birth (Month, Day 1 / 22 / 194	v, _{Year)} 9 8 45 Was	nthplace (State or Foreign country) hington, DC
Maryland 21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-1 show dical Examiliat must be redified at	Funeral Director	10a. State 10b. County DC 10e. Street and Number 5435 C St. S.E.		10c. Cit	y, Town or Lo	Washingto	n, DC 20019		10g. Citizen of What C USA	10d. Inside City Limits 12 Yes 2 □ No country?
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arylan	id be enta ked ic ev	To Be	Unkno 19a. Informant's Name/Relationship (Type, Print)			g Address (Street a	nd Number or	Unk	nown r, City or Town, State,	Zip Code)
	is 1 and of Health item 27 other tr		Keisha Dennis/ Da 20a. Method of Disposition 1 Burial 2 Cremation 3 D	Removal from St	ate C	lace of Dispo emetery, cren	7 Red Jad sition (Name of natory or other place	9)	Date	20c. Location - City or	Town, State
Baltimore,	permit. Page Department of Important: If eny injury or once.		4 Donation 5 Other (Specification 21. Signature of Fineral Service Licenses)		Riv	22	Cremator Name and Address 74 Landov	s of Facility	J.B. Jenki	Riverdale, ns Funeral , MD 20785	Home
8760,	Physician bulk and was the paralitransit superprise the paralitransit supe	dical Examiner	23a. Part1. Enter the disease, or companion, shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or Due to (or c.	a line.	uence of): Le vence of): Le te	eeno S	shoc	K		Approximate Interval Between Onset and Death Clary
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ā	To the Hospital or Attanovithin 24 hours after death To the Funeral Director:	edical Certl	29a. Certifying Phy	sician: To the be	etc. (Specify	vledge death	occurred at the time	o, date and pla	City or Town	, State)	
	To the I within 24 To the F complete	Medi	29b. Signature and title of certifie	and manner	s or examinati	on and/or inv	29c. License	nion, death oc	curred at the time, da	ate and place, and due	to the cause(s)
2			30. Name and address of person who d	ompleted cause of	death (Item	23a) (Type, F	Print) RA	VINDE	PK. Re	20 785	MO .
	Sta Registr		31. Date filed (Month, Day, Year)	2. Regi	strar's Signati	иге	é a	/			

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra: Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 7, 2006 **Physician** Ella Louise Easterday /Medical 11:20 A 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 9265 Brown Church Road Mount Airy Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthptace (State or Foreign Country) 1 □ M 2 🔀 F Yrs. 213-48-3383 Director 90 7, 1915 Oct. Maryland Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 28a-1 show 10d. Inside City Limits traumatic evant, the Madical Examiner must be notified at Montgomery Maryland Mount Airy Directo 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 9265 Brown Church Road Items 23a 21771 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ------any injury or other traumatic event 1 Never Married 2 Married 1 ☐ Yes 2 → No If Yes, Give X Year or Dates: 1 ☐ Yes 2 X No Specify: Completed by 3 XWidowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrator Well Drilling 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 2 Daniel Webster Margaret Eckrode 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21754 19a. Informant's Name/Relationship (Type, Print) R. Olive Burns - Daughter 11650 Browningsville Road, Ijamsville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State ' 4 ☐ Penation 5 ☐ Other (Specify) Mt. Olivet Cemetery 1/11/06 Frederick, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONGESTIVE HEXPLY FAILURE disease or condition resulting in death) MONTHS /Medical Due to (or as a consequence of): Examiner CHRONIC RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury MONTHS Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy ρ Day 4☐Pregnant at time of death 5 ☐ Other (specify) Year the 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of After 28d. Describe how injury occurred 1 X Natural 5 Pending 4 hours after death. Funeral Diractor: A death. investigation 1 Yes 2 No 2 Accident the 6 ☐ Could not be 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D4479 January 9, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20876 AHIN M.D BOLAND GERMANTONN, MO 31. Date filed (Month, Day, Ye 32. Resistrar's Signature State 2006 Registra

			1 - State Registrar	te of Maryland		t of Health and Me of Death		ene 1. No. 2 0 0 6	01398
	Q	6	Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physici /Medi		DOROTHY &	FLO	ソク		Month 01-07-2	Day Year	5:00a M
}	Examir		4a. Facility Name (If not institution, give street a	nd number)	4b. City,	Town, or Location of Death		4c. County of Dea	
			Calvert County Nur	sing Cente	er Pri	nce Frederi	ck	Calve	rt
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) If Under	1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, 1)	(ear) 9. Bir	thplace (State or Foreign puntry)
	Director		220-07-9191 1 ¹ M 2	X 84	Yrs.		11-05-1	921 M	aryland
	and *		Usual Residence of Decedent 10a. State 10b. County	10c, City, To	own or Location				10d. Inside City Limits
	sho	5	MD Carroll						1 ☐ Yes 2 ☑ No
	the A	ect	10e. Street and Number	l no	ampstead 10f. Zip	Code	10-	022	
	with	2	3600 Hampstead Mex	iao Doni			100	Citizen of What Co	ountry?
	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-f show he Medical Exeminer must be rectified at	Funeral Director		s Decedent Ever in U.S.		21074	noifu Vac as Na	USA 14. Race - Ame	rican Indian
4.0	ter d	'n	Am	ned Forces?	If Yes, spec	lent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whit	
38	urs al	b	3 ☑ Widowed 4 □ Divorced Yes	Yes 2 No es, Give ar or Dates:	1 ☐ Yes	X □ No Specify:		Specify: W	nite
21215-0036	2 hou	ted	15. Decedent's Education	10	6a. Decedent's Usua	d Occupation	16	bb. Kind of Business	
715	7 nic 7.	Completed	(Specify only highest grade comp Elementary/Secondary (0-12) Col	leted)	(Give kind of wor life. DO NOT us	rk done during most of work se retired)	ing		,
217	d with	Eo	11	lege (1.401.57)	Secre	tary		Medical	Office
b	il Hygid other vent, I	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Ma	iden Sumame)	
<u>a</u>	outd be f Mental H larked of	To	Thomas Edward	Hooper		Mary	E. Bro	wn	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. tiem 27 is marked other then "naturel", or items 23e or 28a-f show other traumatic event, I'm Medical Examiner must be rediffed as	ľ	19a. Informant's Name/Relationship (Type, Prin	nt) 1	9b. Mailing Address	(Street and Number or Rura	l Route Number, C	City or Town, State, 2	Zip Code)
	1 and 2 Health a em 27 I ther tre		Bonnie L. Hook - D	aughter 4	695 Calv	vert St., P	rince F	rederick	MD 2067
ore.	es 1 and 2 of Health fitem 27 r other tr		20a. Method of Disposition	20b. Place	of Disposition (Nametery, crematory or of	ne of		c. Location - City or	
Ĕ			Y Burial 2 □ Cremation 3 □ Remova '4 □ Donation 5 □ Other (Specify)		stead Ce		1-06 н	ampstead	I. MD
altimore,	p+rmit. Pag Department Importent: I any injury o		21. Signaturi of Funeral Service Licensee		22. Name an	d Address of Facility E1	ine Fun	eral Hom	ie
8	FQ = # 9		Tailles X/Tack	MOO550	934 S.	. Main St.,	Hampst	ead, MD	21074
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. D	o not enter the mode	e of dying, such as cardiac of	r respiratory arrest	,	Approximate Interval Between
E	Priysician				1816 (DOLONG 17	16		Onset and Death
	/Medical		resulting in death)	ue to (or as a consequence	pe of):	TOWES	<i>/</i> —		TUTE
П	Examiner		Consumation that any distance	BILE D	UCT S	TOINES			3000
		ner		ue to (or as a consequence					
	cutec nd ransi	Examiner	that initiated events						
oʻ	e exe	Ä	resulting in death) Last	ue to (or as a consequenc	e of):				
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9	leath certifica attending ph I for use as the		IF FEMALE:						
Вох	th ce tendi	Physician/Me	23b. Was decedent pregnant 23c. If yo	es, outcome of pregnancy Live birth 2 Fetal dea	ith 3⊟Ectopic pre	egnancy		23d. Date of deli	,
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P.0	that the de ed by the detached	Phy.	9 ☐ Onknown	F-1950-			-		
	res tha igned be det	by	Part II. Other significant conditions contributing	g to death but not resulting	g in the underlying ca	ause given in Part I.		cco use contribute to	
ord	w requir been si should	ted					1 Tes	2 No 3 Pro	obably 4 Unknown
ecords,	e law r has be je 2 sh	Completed					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
\propto		Ö					performed	d? death?	2 □ No
Vital	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?			26. Place of Death			
of V	Physiclen: this certific al director,	2	1 Yes 2 No Hospital	1 ☐ Inpatient 2 ☐ ER/0	Outpatient 3 DO	A Other: Nursing Hor	ne 5 Residenc	e 6 □Other (Spec	eity)
0			27. Manner of Death 1 Natural 5 Pending 28a.	Date of Injury 28b (Month, Day Year)	o. Time of 28		8d. Describe how		
Sio	Attending r death. actor: After by the fune	ati	Accident investigation		М	1 ☐ Yes 2 ☐ No			
Division	l or Attendater death after death Director:	Certification;	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, building, etc. (Specify)	farm, street, factory	, office 2	8f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by								
	Hospitel 24 hours Funeral tely filled	edical	Check only 2 Medical Examiner: On	the basis of examination a	lge, death occurred a and/or investigation,	at the time, date and place, a	and due to the caus	e(s) and manner as	stated. to the cause(s)
	To the H within 24 To the Fi complete	Med	and	d manner stated.					
	Mark Too		29b. Signature and title of Sertifier		29c.	License number		Date signed (Month	, Uay, Year)
	MIN					D 2965		114/06	7
	10		30. Name and address of pa so who complete						
-					oital Wa	y, Prince H	rederic	k, MD 2	0678
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature					
	Registr	वा	JAN 1 2 2006	Bloder L	F Branch				

DHMH 17 Rev 1/2001

			1 - State Amend Item	State of Mar 5 Per In				R	eg. No.	06	01399
3	Physic	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medi	cal	Allen Eugene E			T 6% T		01	06	2006	7:10 A ^M
	Exami	ner	4606 Lower Beck	leysvil		Hampst				nty of Death	
4/	Funeral Director		5. Secial Security Number 0 212-42-8150 Usual Residence of Decedent	7. Age (I	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.		Year)		ace (State or Foreign try) jinia
	/land		10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10	Od. Inside City Limits
	Man Bef sh	to	MD Carroll	I	Hampstead						1 ☐ Yes 2 ☐ No
	72 hours after death with the Maryland Instural; or Items 23s or 28s f show disal Examinar must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen o	of What Count	try?
	ath w	rai	4606 Lower Beckley			21074			USA		
	er de	nue		Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- to Rican, etc.)		lace - America lack, White, e	
36	irs aft	by F	1 ☐ Never Married 2 ∰ Marned 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates:		1 □ Yes 2 th No	Specify:		Spec	city: Whi	te
Ö	"natural", or	ted	15. Decedent's Educat	ion	16a. Dece	dent's Usual Occup	pation		16b. Kind of	Business/Ind	ustrv
215	within 7 ene. than "n	pie	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of word)	rking			
2	be filed within 72 ho ital Hygiene id other than "natur event, Ira Musiferi	Completed		5+	Tru	ck Drive	r		Truck	ing	
and		Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, I		ame)	
<u>Ş</u>	d 2 should be th and Mental 7 Is marked o traumatic eve	P P	George Donald Str		401. 14			linor Gis			
Maryland 21215-0036	o,		19a. Informant's Name/Relationship (Type, Rosalie Rae Fields			ng Address (Street					
	ages 1 and 2 int of Health it: if Item 27 I		20a. Method of Disposition		20b. Place of Dispo	Lower Bed				ead MD n - City or Tov	
9	Pages nent of nnt: if its		1 ☐ Buriaf 2 # Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	Carroll C	matory or other place remation	1	20.40.0		ead MD	
Baltimore,	는 문원를		21. Signature of Funeral Service Licensee			2. Name and Addre	on of English				
ã	Depa Impo any i		Steven W.	Eline r	100723 9	34 South	Main Str	ine Fune eet Hamp	raı Ho stead	ome MD 21	.074
	Physician /Medical Examiner	er	23a. Pant1. Enter the disease, or complicat shock, or heart failure. List only one of limediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of):	er the mode of dyin		Ins	1	1	Approximate finterval Between Oneet and Death
68760,	requires that the death certificate be executed een signed by the attending physicisn and nould be detached for use as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a co	onsequence of):						
.O. Box	at the death certific by the attending p tached for use as it	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of p 1 Live birth 2 4 Pregnant at time 9 Unknown	Fetaf death 3	Ectopic pregnancy Other (specify)				Date of deliver Month C	y Day Year
ords, P	w requires that been signed be should be det	þ	Part fl. Other significant conditions contrib	outing to death but no	ot resulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	V		cause of death?
	The law ate has b page 2 si	Completed						24a. Was ar autopsy perform 1 Yes 2	18.	prior to com death?	sy findings available pletion of cause of
Vital	Physicien: This certifical	o Be	25. Was case referred to medical examiner?	oital:	ACI 50/0	Othe	05	th (Check only one			
ō	g Phys er this eral di	-	27. Manner of Death	28a. Date of Injury	2 ER/Outpatien	1 3 DOA	4 Inursing n	ome 5 Resider 28d. Describe ho		ther (Specify)	
<u>0</u>	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	nar) Injury		k? Yes 2 □No				
Division of	To the Hospitef or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre Specify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Nun State)	nber or Rural I	Route Number,
	To the Hospitef or within 24 hours afte To the Funeral Director Completely filled in the Funeral Director Completely filled in the Completely fill	Medicai	29a. Certifier (Check only one) 1 Certifying Physici 2 Medical Examiner:	an: To the best of m On the basis of exa and manner stated.	amination and/or inv	occurred at the time restigation, in my op	ne, date and place, pinion, death occur	and due to the ca rred at the time, da	use(s) and n te and place	nanner as stat o, and due to t	ted. he cause(s)
	Vith Vith Comp	Σ	29b. Signature and title of certifier		~ >	29c. License	number	29	d. Date sign	ed (Month, Da	ay, Year)
•	WJL		Ih Ih		MI,U.	Dog	573	35	1/	9/06	
	12		30. Name and address of person who comp		(Item 23a) (Type, I	Print)	01 1	0-04	(, .	0 11	17021289
100	m (ii) No. 1		Han O. Sohn	32 806	Loch	Kaven	BIUd	KOR #	64	Balt.	17021289
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Clara Margaret Freyman January 04 2006 10:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Dennett Road Manor Nursing Home Oakland Garrett 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Min. 1 □ M 2 □X€ Days Hours Director 212-24-2868 April 19 1910 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28e-f show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 XYes 2 No MD Garrett Oakland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? itams 23e 1113 Mary Drive 21550 Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 is marked othar than "natural", or itams 23 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes If Yes, Give 1 Never Married 2 Married 2/2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: by White 3 Nidowed 4 Divorced Specify: Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4+ School Teacher Education 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) George Henry Sterner Ada Schaeffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a :: If itam 27 is or other tra William Freyman, Jr/son 280 Paradise Acres Rd Oakland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 01/07/2006 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Meadow Branch Cemetery Westminster, MD 21. Signature of Juneral Service Lice Fricts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enterne diseas Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrovascular Insufficiency /Medical vears Due to (or as a consequence of): Examiner Sequentially list conditions, it and the sequential sequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or). The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. by Physician/Medicai the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) detached of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2. No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 🗆 No 1 Yes Hospital or Attanding Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) after death. I Diractor: After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Injury 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To tha Funaral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) completely To tha 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MJL D15333 05/2006 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas G. Johnson, M.D. 311 N Fourth Street Oakland, MD 21550 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 0 9 2006 Registrar Clave & Joseph

DHMH 17 Rev 1/2001

Registra

			For State Registrar	State of M	Marylar		artment rtificate				ental Hy	gien	7 11 11 15	. () 4	02
	Physici	an	1. Decedent's Name (First, Middle, I Calvin Leon (,							2. Date of De Month Januar	eath D	ay 2006	ar	3. Time of 4:17	Death
	/Medio		4a. Facility Name (If not institution, g	give street and number	ir)		4b. City, To			of Death	Janua	4	c. County of D	eath	4.1/	
· 16-16-16-16-16-16-16-16-16-16-16-16-16-1	Funeral Director		5. Social Security Number 186-32-9123 Usual Residence of Decedent	. Sex 7. / 1⊠M 2□F	Age (In yrs. 66	last birthday) Yrs.	If Under 1 Months [Year Days	Hours	Min	8. Date of Bir (Month, Da Sept.	rth ay Year 15,	1939 S	Birthplac Country Outh	Car	or Foreign olina
	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked other than "natural", or items 23s or 28s-1 show umatic event, its Madical Example or must be notified at	ector	10a. State 10b. County Maryland Montgo	omery		y, Town or Lo									. Inside Ci	•
	23a or	Funeral Director	7600 Glackens I	rive			10f. Zip Ci						ted Sta		7	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iteme 23a or 28a-1 show any injury or other traumatic event, the Madical Examinatinal hamolified at once.	b	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 X Yes 2 [If Yes, Give Year or Dates	s? 1968]No	- '	Was Deceder f Yes, specify 1 ☐ Yes 2		panic Orig , Mexican, Specify:	gin? (Spec i, Puerto P	cify Yes or No Rican, etc.))-	14. Race - A Black, W Specify:	hite, etc		
Maryland 21215-0036	d within 72 h giene. ir then "natu	Completed	15. Decedent's (Specify only highest g	Education trade completed) College (1-40 5+	r 5+)	(Give life. l	dent's Usual C kind of work DO NOT use Sician	done du	ion ring most	of workin	g		Kind of Busine Medicia		itry	
yland	nould be file d Mental Hyg narked othe natic event,	To Be C	17. Father's Name (First, Middle, La. David Griffin,	Sr.					Chri	istin	(First, Middle le Trib	b1e				
	1 and 2 st Health and 10m 27 Is n other traun		19a. Informant's Name/Relationship Florence E. Grif		2)	1					mac, M		or Town, State 20854	a, Zip Co	ide)	
Baltimore,	Pages 1 nent of H. int: If Iter		20a. Method of Disposition 1 ABurial 2 Cremation 3 4 Donation 5 Other (Spec		e C	lace of Dispo emetery, cren e of H	natory or othe	r place)		1/6/			ocation - City Ver Spr			
Balti	permit. Departm Imports any Inju		21. Signature of Funeral Service Lic		ou/	/ 22	. Name and A	Address	of Facility	McG	uire F	une	ral Ser	vic	2	0012
8/60,	the death certificate be executed X the attending physicien and cheed for use as the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or co shock, or heart failure. List online disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	y one cause on each	tic A s a consequence of a consequence o	denoca uence of): uence of):						rrest,		l In	pproximate lerval Betv nset and E	veen
.C. Box 6	the death certific y the attending p tched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant : 9 □ Unknown	2 Fetal	death 3	Ectopic pregr Other (specified)						23d. Date of o	lelivery Da	y Y	ear
ecords, P	gne be	þ	Part II. Other significant conditions Renal Failure	contributing to death	but not resu	ulting in the un	derlying caus	e given	in Part I.				use contribute			
r	The la ate has page 2	Completed	Hypertensive Car	rdiovascu1	ar Dis	sease					24a. Was autop perfor	sy rmed?	24b. Were prior to death	o comple?	etion of ca	vailable use of
r vitai	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpat	ient 2 🗆 l	ER/Outpatient	3□ DOA				Check only o		6 ∐Other (Sµ	pecifu)		
DIVISION OF	ttending Physideath.		27. Manner of Death 1 Natural 5 Pending 2 Accident investigate		ury ay Year)	28b. Time of Injury	28c.	Injury a Work?	t s 2∐N	28	d. Describe h	now inju	ry occurred	,		
Ĭ	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After chmpletely filled in by the funeral or the funeral o	Certification:	3 Suicide 6 Could not determined	d 286. Place of Ir building, e	tc. (Specify	·) 					City or Tow	ın, State				·e <i>r</i> ,
	thin 24 ho thin 24 ho the Fund mpletely f	edical	29a. Certifier 1 Certifying P (Check only one)	hysician: To the besi nminer: On the basis and manner s	ot examinati	viedge, death ion and/or inv	occurred at the estigation, in	ne time, my opin	date and ion, death	place, an occurred	d due to the o	ause(s date and) and manner d place, and d	as stated ue to the	d. cause(s)	
)	2 (5)	Σ	29b. Signature and title of certifier	Umar	slia	OD DI		cense n					te signed (Moi uary 4			
0	XSO		30. Name and address of person who Lewis W. Marshal			23a) (Type, F Jarnum	Print)			Was	hingto			2001		
	Sta Registra		31. Date filed (Month, Day, Year) JAN 0 6	2006 32. Regist	rar's Signat		well .		-							

			1 - For State Registrar 1. Decedent's Name (First, Middle, La	State of Maryl		artm		lealth an		ygien Reg. N	enns (01403
	Physic /Medi Examir	cal	Allen 4a. Facility Name (If not institution, given	Gree	en	4b. (City, Town, o	r Location of D	2. Date of D Month Januar	у 2 ^р ,	ay Year 2006 c. County of Death	3. Time of Death 8:42 A.
	Funeral Director		5 Lazy Hollow Way 5. Social Security Number 6. S 076-12-8728 Usual Residence of Decedent		yrs. last birthday, 82 Yrs.	If U	nder 1 Year			ay, Yea		ry lace (State or Foreig try) York
	Ba-f show	ctor	10a. State 10b. County Maryland Montgot		City, Town or Li Gaithers		g				1	0d. Inside City Limit
:	23a or 2	Funeral Director	10e. Street and Number 5 Lazy Hollow Way	7		1 Of.	Zip Code 208	78		10g. C	itizen of What Coun	itry?
2	o within 72 hours after death with the Maryland Jene. Then "neturel", or Items 23s or 28s-f show Ite Madical Examinar is ust be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever i Armed Forces? 1 X Yes 2 □ No A If Yes, Give Year or Dates: WW	rmy	If Yes,	ecedent of H specify Cuba s 2X No	lispanic Origin? an, Mexican, Pu Specity:	(Specify Yes or N erto Rican, etc.)	0-	14. Race - America Black, White, e Specify: Wh	
	giene.	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12 Years	ducation ide completed) College (1-4or 5+)	(Give	kind oi DO NO	Isual Occup work done Tuse retired	during most of a	working		Kind of Business/Ind A and H Radio & T	,
	nound be med d Mental Hygia narked other natic event, II	To Be	17. Father's Name (First, Middle, Last, (Unknown) 19a. Informant's Name/Relationship (Green			Ann		e, Maide	n Sumame) (Unknown)	
	perimit. Tages I and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other treumatic events.		Helen Green - Wif 20a. Method of Disposition 1 ♀ Burial 2 □ Cremation 3 □	e 200	5 La. b. Place of Dispo cemetery, crem	zy I	Iollow Name of or other place	Way, G	aithersb Date	urg,	or Town, State, Zip Maryland ocation - City or Tow	20878
	Departme Important any injury once.		4 Donation 5 Other (Specification 21. Signature of Funeral Service Licer	Stottlem	yes D	Name nza 170	and Address nsky- Rocky	ss of Facility Goldber ille Pi	g Memori ke. Rock	al C	ey, Maryl hapels, I e, Maryla	
E	hysician and phasician and the prujar-transit	I Examiner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a constitution of the consti	Cancer sequence of):					arrest,		Approximate Interval Between Onset and Death
The law recoilings that the death and desired well add	ned by the attending physical detached for use as the L	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d. 23c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of	etal death 3		pregnancy (specify)				23d. Date of deliver Month	y Day Year
ted that	been signed b	by	Part II. Other significant conditions c	ontributing to death but not	resulting in the ur	nderlyin	g cause give	in in Part I.	23e. Did t		use contribute to the	cause of death?
	ificate has be or, page 2 sh	e Completed	25. Was case referred to medical						1 □ Yes	psy prmed? 2 X No	prior to com death?	sy findings availabl pletion of cause of
hvaici	nis cer I direct	ToB	examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatien	3[]	DOA Othe		eath Check only of		6 □Other (Specify)	
Attending Physician:	within 24 hours efter death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Certification;	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			М		at	28d. Describe			
To the Hospitel or A	within 24 hours efter To the Funerel Director completely filled in by	I Certif	4 Homicide determined	28e. Place of Injury - Albuilding, etc. (Spe	icity)				City or To	wn, State		
the Hos	hin 24 h the Fur npletely	Medical	one)	ysician: To the best of my kiner: On the basis of examinand manner stated.	nation and/or inv	estigati	on, in my op	inion, death oc	ce, and due to the curred at the time,	cause(s) date and	and manner as stai place, and due to t	ted. he cause(s)
To	1 2 b	Σ	29b. Signature and utle of certifier	Salem .	W	2	9c. License	number 142586			uary 2, 2	
٥	Sta Registra		30. Name and address of person who catherine I. S 31. Date filed (Month, Day, Year)		0 W. Gu	,	rive,	Rockvi	lle, Mar			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day}, 2006 January **Physician** 9:30 Mande Glasgow /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Salisbury Wicomico 229 N. Clairmont Drive If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 8. Date of Birth (Month, Day, Year) 1/21/1910 5. Social Security Number 7. Age (In yrs. last birthday, Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 215-24-7294 95 Yrs Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County or 28s-f ahow other traumatic avent, the Madical Examiner must be notified at Y□Yes 2□No Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 21801 229 N. Clairmont Ave. USA or itama 23a filed within 72 hours after death Hygiene. yther than "natural", or itama 23 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: white þ 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic es 1 and 2 should be filed w of Health and Mental Hygier f Itam 27 is marked other ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas W. Davis Mary Alice Truitt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sl Department of Health and Important: If Itam 27 is r any injury or other traur 8535 Marlboro Dr., Delmar, MD 21875 Bill Davis/nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/9/06 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service Licensy 22 Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) pertensin **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical 98 the attending IF FFMALE esn. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Year for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 99 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? res 2 No this certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physician: funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 🗌 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 🗆 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Dafe signed (Month, Day, Year) 29b Signa certifier 90b to completed cause of death (Item 23a) (Type, Print) 30. Name and perso Ma 32. Aggistrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 9 2006 Board Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 1, 2006^{ear} Clayton Standsbury Grimes /Medical 10:20 a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Fort Washington Hospital Fort Washington Prince George If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1X M 2□ F **Director** 214-48-7237 59 Yrs. Nov. 5,1946 Maryland Usual Residence of Deceden filed within 72 hours after death with the Maryland 10a, State 10h. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits s 23a or 28a-f shows the state of the state Director Maryland Charles 1 XYes 2 □ No Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Oak Street 20640 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No If Yes, Give Year or Dates: or Itams 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: White ar than "natural", the Madical Exa 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Pages 1 and 2 should be filed w thent of Health and Mental Hygier tant: If itam 27 is marked other th ijury or other traumatic avant; Heavy Equip. Operator Electrical Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Aron S. Grimes 2 Effie M. Cooksey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy M. Grantham 5 Oak St., Indian Head, Md. 20640 Sister 20b. Place of Disposition (Name of cemetery, crematory or other place). Jan. 9ate 2006 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once. TRINITY MEMORIAL GARDENS Waldorf, Maryland 21. Signature of Funeral 22. Name and Address of Facility
Williams Funeral Home, P.A.
4370 Hawthorne Rd.Indian Head, M00668 Md.23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or ifear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Acute Cornary Insufficiency resulting in death) /Medical Due to (or as a consequence of): Examiner A.S.C.V.D. Sequentially list conditions, harry, leading to infrastrate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner or Attanding Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 20XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending death. investigation thours after death. 1 ☐ Yes 2 ☐ No 2 Accident illed in by the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as to the cause(s) and manner stated. 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D0007967 Vanuary 3, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Albert E. Rolle, M.D 600 Riverbend Rd., Fort Washington, Md. 20744 31. Date filed (Month, Day, Year) 32. A gistrar's Signature State JAN 0 6 2006 Registrar

		•	For State Registrar	State of	Marylan	-	artment of F		d Mental Hyç	gieņe Reg. No. 006	01406
	Physici	an	Decedent's Name (First, Middle, Last						2. Date of Dea Month	Day Yea	
	/Medic		CROMER GRIME				di Chi T	1	Jan. 7	, 2006 4c. County of De	1:55 A ^M
	Examin	er	4a. Facility Name (If not institution, give Future Care Nursi				4b. City, Town, o		eatn	,	
-	Funeral				Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 I		Prince (irthplace (State or Foreign Country)
	Director		717-10-2526	X M 2□ F	83	Yrs.	Months Days	Hours N	Dec. 7,	1922 Vir	ginia
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. City	/, Town or Lo	cation				10d. Inside City Limits
	Maryli feho	ō	Maryland Charles			laldorf					1 ☐ Yes 2X☐ No
	deeth with the Maryland rms 23a or 28e-f ehow rmust be notified at	Funeral Directo	10e. Street and Number		W	ia i u u i i	10f. Zip Code			10g. Citizen of What	Country?
	h with	al D	11080 Weymouth Ct	., Apt.	122			20602		US	
	eep .	iner	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.	S. 13. \	Was Decedent of H	lispanic Origin? an, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ar Black, Wi	nerican Indian,
36	hours after turel', or its	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 (X) Yes 2 If Yes, Give Year or Date			1 ☐ Yes 2 ☒ No			Specify:	White
21215-0036	72 hours after deeth with the Marylan "neturel", or Items 23e or 28e-f ehow oftes! Examiner must be notified at		15. Decedent's Ed		35.	16a. Deced	dent's Usual Occup	ation		16b. Kind of Busines	s/Industry
215		plet	(Specify only highest gra	de completed) College (1-4	or 5+)	(Give life. I	kind of work done OO NOT use retired	during most of d)	working		,
21;	ad with	Completed		4		Carp	enter				uction
Maryland	s 1 and 2 should be filed withir f Heelth and Mental Hygiene. Item 27 le marked other then other treumatic event, the M	Be	17. Father's Name (First, Middle, Last)						Name (First, Middle,	Maiden Sumame)	
Z	hould d Mer marke matic	ဥ	Thomas Allen Grim 19a. Informant's Name/Relationship (7)			19h Mailin	a Address /Street		linesett	r, City or Town, State	Zin Code)
Ma	nd 2 silth an 27 le r		John Grimes - Son	ypa, riini)		1	•			le, MD 206	
	s 1 ar f Hee ftem other	1 3	20a. Method of Disposition		20b. P		sition (Name of natory or other place	nal	Date	20c. Location - City	
Ë	Page nent o nt: If		1				emorial		11-06	Waldorf, M	D
Baltimore,	permit. Pages 1 and 2 Depertment of Heelth a Important: If Item 27 Item V Injury or other tre ance.		21. Signature of Funeral Service Licen	MO12	46	22	. Name and Addre	ss of Facility		ld Washing	
	20E 20		Nact A. Willy	~							, MD 20604
	Physician /Medical Examiner		23a: Part1. Enter the disease, or comy shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Cardi Due to (or	ch line. opulmo as a consequ stive	nary f uence of): Heart		ig, such as can	Glac or respiratory an	1031,	Approximate Interval Between Onset and Death
8760,	ate be executed hysicien and the burial-transit	Ilcal Examiner	Exquantially let sonditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Cardi	as a consequence of a consequence of as a consequence of as a consequence of a consequence	thy					
Ö	ertifica Jing ph	Med	IF FEMALE:	220 16	of						
P.O. Box	it the death certifica by the ettending ph tached for use as it	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		h 2 ☐ Fetal it at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
	gned good	ρ	Part II. Other significant conditions of Hypertension	ontributing to dea	th but not resi	ulting in the u	nderlying cause giv	en in Part I.			to the cause of death? Probably 4 Unknown
Division of Vital Records,	The law r le hes be age 2 sh	Completed							24a. Was autop	sy prior to med? death	
ita	ician: T certifice rector, p	BeC	25. Was case referred to medical examiner?					26. Place of	Death Check only or		
₹	Physician: this certific ral director,	၉	1 ☐ Yes 2 🕱 No	Hospital: 1 inp				4 (24) 14(15)11		lence 6 Other (Sp	pecify)
n c	of the land	ii o	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 ☐ No	28d. Describe h	ow injury occurred	
isi	death. death. ctor: A	lcat	2 Accident investigation 3 Suicide 6 Could not be		f Injury - At he	ome, farm, str	eet, factory, office	165 2010	28f. Location (S	Street and Number or	Rural Route Number
οį	efter Dire d in b	Certification:	4 Homicide determined	building	, etc. (Specify	v)	,,,		City or Tow		
	To the Hospitel or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fi	Medical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the b niner: On the bas and manne	is of examina	wledge, death tion and/or in	n occurred at the tir vestigation, in my o	me, date and pi pinion, death o	lace, and due to the occurred at the time, o	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	12			29c. Licens	e number	!	29d. Date signed (Mo $01-08-2$	
7	,=		700000	Y	-4	00-1 7		320		2,-00-2	0.40 C
de	B5?		30. Name and address of person who Bahram Pishdad,	MD, 1328	South	ern Av	e., SE,	#310, W	ashington	DC 20032	
	Sta Registi		JAN 0 9 2	006	gistrar's Signa	ture J. J.	books				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 407 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month Day Year **Physician** Gertrude Hoffman L. 2006 6:46 A. January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 23, 1914 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 ☐ M 2 🖸 F 91 Pennsylvania 410-52-2408 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: if tiem 27 is marked other than "natural", or items 23a or 28e-f show injury other traumatic event, the Medical Examinat must be notified at a. Maryland IX Yes 2 □ No Montgomery Gaithersburg Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 407 Russell Avenue #710 20877 United States Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after compartment of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or item any injury other traumatic event, the Martland once. Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: White Specify: <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Children Services Social Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Samuel Chesnut Hoffman Orris Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Julia Anne Hoffman/Neice 331 East 29th Street New York, NY 10016 20b. Place of Disposition (Name of 20c. Location - City or Town. State 20a. Method of Disposition Januarv Geo. Wash. University 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 2006 4 □ Other (Specify) Medical Center 22. Name and Address of Facility Columbia Mortuary Services, Inc. 21. Signature of Funeral Service Licens P.O. Box 58007 Washington, D.C. 20037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 24 Hours O Cardia /Medical Due to (or as a consequence of) **Examiner** Due to (or as a gonsequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physicien and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pe 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 2 No 1 Yes the Hospitei or Attending Physicien: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident within 24 hours after death To the Funerel Director: , completely filled in by the f 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D21334 3, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) .20850 15235 Sdack anel Golden Gove 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 06 2006 Registrar

			1 - For State Registrar	State of M	arylan		artmer rtificat				F	Reg. No	4000	0	408
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	Funeral Director		5. Social Security Number 577–88–2361 6. Se Usual Residence of Decedent	7. Ag	ge (In yrs. 47	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day March		9. Bin	thplace (Sta	on, D.
	se Maryland 8a-f ehow	ctor	10a. State 10b. County Maryland Montgomer	У	1	y, Town or Lo									e City Limits
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036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23a or 28a-f show any lury goother treumatic event. The Madical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Microroced	12. Was Decedent Armed Forces? 1 Yes 25 If Yes, Give Year or Dates:	,		Was Deced If Yes, spe		spanic Origin n, Mexican, F Specify:	n? (Spec Puerto R	ify Yes or No- lican, etc.)		14. Race - Ame Black, Whit Specify: B1a	e, etc.	١,
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/Medic Examin		4a. Fecility Name (If not institution					4b. City,	Town, or	Location o	of Death	01 07		County of Dea	
Examin	Ŭ.	Saint Josep	h Medi	cal C	ente	er	To	owsc	n			В	altim	ore
Funeral		5. Social Security Number	6. Sex		In yrs. last		If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. Bi	rthplace (State or Foreign country)
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		I him that title	MD	Des	uty		0	18	عاما د	7		Jan	uarv	8,2006
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			1 - For State Registrar	State of Mary		partment e <i>rtificate</i>			Mental H	ygieni Reg. N	とせせも	014	
	Physici /Medio		1. Decedent's Name (First, Middle, La James Frederick						2. Date of D Month Januar	Da	2006 Year	3. Time of 2:20	Death a M
	Examir		4a. Facility Name (If not institution, given Holy Cross Hosp.					cation of Death Spring		40	c. County of De Mont	ath gomery	
	Funeral Director		377-03-3845	OKU OFF	yrs. last birthda 91 Yrs.			Under 24 Hrs. Hours Min.	8. Date of B (Month, L Dec • 3	irth ay, Year I, I	914 9. B	irthplace (State of Sountry) Vew York	r Foreign
	Maryland B-f show	tor	Usuel Residence of Decedent 10a. State 10b. County Maryland Montge		c. City, Town or	Location Sprin	g					10d. Inside Ci 1 ☐ Yes	
	th with the 23a or 28	Funeral Director	10e. Street and Number 3118 Gracefield	Road, CC 11	5	10f. Zip C	0904			10g. Ci	itizen of What (Country?	
020	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then *natural', or Items 23a or 28e-f show emportant: if Item 27 is marked other then *natural', or Items 23a or 28e-f show emportant: if Item 27 is marked other traumattic event, Item Medical Exaction traumatic event, Item Medical Exaction to an analysis of the profiled at once.	b	11. Marital Status 1 Never Married 2区 Married 3 Widowed 4 Divorced	12. Was Decedent Evel Armed Forces? 1 ဩYes 2 ☐ No If Yes, Give Year or Dates: WW		I. Was Decede If Yes, specif		anic Origin? (S Mexican, Puert Specify:	pecify Yes or No Rican, etc.)	lo-	14. Race - An Black, Wh Specify: Wh		
0-61717	e filed within 72 ho al Hygiene. I other then "natur vent, the Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5+)	life.	edent's Usual ve kind of work DO NOT use	retired)		kıng		Kind of Busines	,	
/land	should be filed and Mental Hygi s marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last William Edward H					. Mother's Nan	ne (First, Middle Chrysle	e, Maidei	n Sumame)		
; Mar)	and 2 sho ealth and ! m 27 is ma		19a. Informant's Name/Relationship (Phil Hadden/ Son		2661	South	Glen		treet,	Salt		City, UT	8410
IIIIOLE	riment of H riant: if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Contro	Removal from State by)	Colesvil	ematory or oth	erplace) etery	20		Со		e, Mary	land
פֿ	permit. Departr Importa eny Inju		21. Signature of Funeral Service Lice	Cole	5	500 Uni	versi	ty Blv		ilve	me Inc r Sprin	ng, MD 2	
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or dome shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. Sepsis Due to (or as a co	onsequence of):	nter the mode	of dying, s	uch as cardiac	or respiratory	arrest,		Approximate Interval Beh Onset and I	ween
,00,	icate be executed physicien and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underthying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	onsequence of):								
O. BOX 00	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after dot alth. To the Funeral Director: After this certificate hes been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	⊟Ectopic preg □ Other (spec					23d. Date of d Month		⁄ear
COLUS, P	quires that an signed b ruld be deta	b	Part II. Other significant conditions		ot resulting in the	underlying cau	use given ir	n Part I.				to the cause of d	
משבו ופי	: The law re cate hes bei page 2 sho	Completed				·			24a. Wa aut per 1 🗆 Yes	opsy formed?	24b. Were a prior to death?	autopsy findings a completion of ca s 2 \(\sum \) No	available ause of
) X	ysician lis certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☑ Inpatient	2 ER/Outpati	ent 3□ DOA	Other		th Check only		6 ☐Other (Sp	ecify)	
	tending Pr death. tor: Alter th the funeral	Certification:	27. Manner of Death 1 XNatural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be			М		2 🗆 No	28d. Describe				
2	pital or Al ours after o erel Direc		4 Homicide determined	28e. Place of Injury - building, etc. (S	Specify)				City or To	own, State	Θ)	Rural Route Num	ber,
	o the Hos ithin 24 hd o the Fun ompletely	Medical	(Check only 2 Medical Example) 29b. Signature and title of certifier	niner: On the basis of exa and manner stated.	amination and/or	investigation, ir	n my opinio	on, death occu	rred at the time	, date an	and manner and du d place, and du ate signed (Mor	ie to the cause(s	
15	7/		30. Name and address of person who	completed cause of death	(Item 23a) (Type		D2403	5			nuary 2		
•			Eugenio Machado, 31. Date filed (Month, Day, Year)	M.D. 3110	Gracefie	eld Roa	d, Si	llver S	pring,M	D 20	904		
	Sta Registr		JAN 06	2006	Signature	as the							

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

AEM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,PIT_27 pen/E_0351,1/25/06 TT State of Maryland / Department of Health and Mental Hygiene () () () 06-00407 Steven Hughes 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 2006 3:12 A M Steven Craig Hughes 16, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 18601 Roxbury Road Hagestown Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2 □ F Yrs. 212-84-9510 Director 5,1961 D.C. Usual Residence of Decedent with the Maryland r than "natural", or items 23a or 28a-f show the Mudical Examinar must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No D.E. Sussex Ocean View 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 19930 19 Mary Elizabeth Dr. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Drafting Construction 12 Ith and Mental Hygid 27 is marked other r traumatic event, ii permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any lighty or other traumatic event SDR. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Arthur Betty L. Wrigglesworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Hughes (Mother) 156 Blue Bird Lane Harpers Ferry, WV. 25414 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Jan. 18, Smithsburg Crematory Smithsburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. Moy414 J.L. Davis Funeral Home Smithsburg, Md. 21783 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause disease or condition resulting in death) mediate Cause (Final Physician Hypertensive Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ĕ in the past 12 months? Day Year 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ of Vital Records, 9 Cirrhosis of Liver 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an hes page 2 autopsy performed' this certificate 1 Yes 2 No After this certification tuneral director. To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 XX es 2 □ No Other: $_{4}$ Nursing Home $_{5}$ Residence XXOther (Specify) Scene ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely tilled in by the tu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

He discal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME January 16, 2006 outhell, ni 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E-Southay, MD

Registrar DHMH 17 Rev 1/2001

State

tameles 31. Date liled (Month, Day, Year)

JAN 2

2006

32. Fee Strar's Signature

111 Penn Street Baltimore, Maryland 21201

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			Registrar 1. Decedent's Name (First, Middle, L.)	acti		OGIL	incate o	Dealit	2	. Date of Dea	leg. Nő.		0.7:	-f D-oth
	Physici /Medi		Russell	Paul		Hall			6	Month 8	Day	Year		of Death
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	差.	ğ.	Peninsula legion		1 (0)	ster	Sal	isbur				WILLOW		
	Funeral		5. Social Security Number 6. 238-07-1751	Sex 7. A	ge (In yrs. I 87	last birthday) Yrs.	If Under 1 Yes Months Day		Min.	(Month, Day	Year)	Ç	rthplace (State ountry)	
	Director		Usual Residence of Decedent		07	113.				11/4/1	9T8	T.e.	nnesse	<u>e</u>
	land bw		10a. State 10b. County		10c. City	y, Town or Loca	ation						10d. Inside	City Limits
	Mary	jo	Maryland Wicom	ico	S	alisbur	v						tX □Ye	es 2 No
	28e	rec	10e. Street and Number				10f. Zip Code)			10g. Citiz	en of What C	ountry?	
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8	ral',	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	Arm	ly II	⊒Yes 2□X	lo Specify:				Specify: wh	nite	
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68	tifical ig ph as th	led									- 1			
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ω.	deal ne att ed for	10 S	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			Other (specify)					Month	Day	Year
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4	5		30. Name and address of person who	completed cause of	death (Item	1 23a) (Type, Pr	n O	nino	(DICO	Un	1 hun	7.60	801
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238-67-1751

Holle Rumel

ADH JULIUS M. HOLDEN 06-0126

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Baltimore, Maryland 21215-0036	s 1 and 2 should f Heelth and Men itsm 27 is marke other trsumatic	-	19a. Informant's Name/Relationshi			19b. Mailin	ng Address	(Street a	ind Numbe	er or Rura	Route Numb	er, City o	r Town, State, 2	Zip Code)	
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Ba	permit. Peg Department Important: sny injury c once.		21. Signature of Funeral Service Li	censee			2. Name and 917 W						th Fun sbury,		
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Вох	eath certifi attending for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnar		Ectopic pre	egnancy				1	23d. Date of del		V
о. П	es thet the death certific igned by the attending p be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnar 9□ Unknow	nt at time of de m	eath 5	Other (spe	ecify)					Month	Day	Year
0	het th ad by detacl	P.	Part II. Other significant condition	s contributing to dea	th but not resu	ulting in the u	nderlying ca	ause dive	en in Part I		23e. Did t	ohacco u	se contribute to	the cause of	death?
Division of Vital Records,	signe signe d be	d by						auto give	J. H. I. G. I.	•	10		V	obably 4	
Ö	w requi	ete									24a. Was	an	24h Were a	utopsy findings	e available
Re	The law rate has be page 2 sh	Completed									autor perfo	psy ormed?	prior to death?	completion of	cause of
ta	ystcian: The is certificate hadirector, page	0	25. Was case referred to medical					-	26. Place	of Death	(Check only	2□ No	1 X Yes	2□ No	
≥	Attending Physician: r death. sctor: After this certific by the funeral director,	To B	examiner? 1√2 Yes 2 ☐ No	Hospital: 1 ☐ Inp	patient 2 🗆 I	ER/Outpatier	nt 3 DO	A Othe					Other (Spe	city) AT S	CENE
0	ng Pł fter tł meral		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time o Injury	f 2	8c. Injury Work	at	2	8d. Describe		v occurred .	ubject	
sio	tendi leath. lor: A the fu	cati	2 ☐ Accident investigation 3 ☑ Suicide 6 ☐ Could no	ation found 1/5	de	found 5'd	J.M	1 🗆 '	Yes 2		hanged	selt	_		
\leq	i or At after o Direct	Certification:	4 Homicide determin	288. Place 0	f Injury - At ho g, etc. <i>(Specif</i> y	()		, office			City or To	Street an wn, State	TIO E	iral Route Nui DILLZCI	
_	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 ☐ Certifying	Physician: To the b	est of my know	Mediden wledge, deat		at the tim	ie, date an		and due to the	Md.		0	
	n 24 h	Medicai	(Check only 2 Medical E	xeminer: On the bas and manne	is of examinat	tion and/or in	vestigation,	in my op	oinion, dea	th occurre	ed at the time,	date and	place, and due	to the cause	(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	. /			29c		number				e signed (Mont		
}	The state of the s		+ Hapete / with	half, ND				0.0	.M.E			JAN 	V. 6, 20	JU6	
	Ma		1) 1 = 2	no completed cause				יים ביים	DAT.	TTMO	DE MADE	7T A N TT	21201		
	1)			thall, Mi)	gistrar's Signat		MIN DII	KELL	, BAL	TTMO	KE, MAR)	LLAINL	21201	· · · · · · · · · · · · · · · · · · ·	
	Sta Registi		31. Date filed (Month Pay Year)		less s		anti								

DHMH 17 Rev 1/2001

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Registrar

			For State Registrar	State of	Marylar		artment of F		Mental Hyg	iene 006	01417
	100		1. Decedent's Name (First, Middle	, Last)					2. Date of Deat Month		3. Time of Death
	Physici /Medio		Barbara A.	Johnson					January	2 2006	10:55a M
	Examin		4a. Facility Name (If not institution	, give street and num	ber)		4b. City, Town, o	r Location of De	ath	4c. County of Dea	ith
		扩	Anne Arundel				Annapol			Anne Ar	undel
	Funeral		5. Social Security Number	6. Sex 7		. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	n (Month, Day,	Year) (C	thplace (State or Foreign ountry)
	Director		214-56-2460 Usual Residence of Decedent		55	115.			Aug. 10	1950 Ma	ryı́land
and	A =		10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation				10d. Inside City Limits
Mary		to	Maryland Anne	Arundel	Anı	napoli	C C				1X∑Yes 2 ☐ No
the	288	Directo	10e. Street and Number	111 0110 01	22111	парод	10f. Zip Code		1	0g. Citizen of What C	ountry?
) with	98	0	1006 Preside	nt St. Ar	ot. S	4	21	403			USA
U Z I Z I 3-0000 filed within 72 hours after death with the Maryland	ms 2	Funeral	11. Marital Status	12. Was Deced	ent Ever in L				(Specify Yes or No- erto Rican, etc.)	14. Race - Am	erican Indian,
affer	or Ite	T.	1X Never Married 2 ☐ Marr		No No		1 ☐ Yes 2 No	Specify:	eno nican, etc.)	Black, Whi	
S syno		d by	3 Widowed 4 Divorced	Year or Dai	es:		10103 2010	Specity.		Specify: B	lack
2 2	netr	Completed	15. Decedent (Specify only highest	t's Education of grade completed)		(Give	dent's Usual Occup	during most of w	vorking	16b. Kind of Business	/Industry
After N	han han	m m	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use retired	,			
y fee	Hygie ther t		10th 17. Father's Name (First, Middle,	(ast)			Securit		cer ame (First, Middle, M		Maryland
= 8	d od o	Be	Thomas John								
ar y ra	nd Me mark mati	P	19a. Informant's Name/Relations			19b Maili	no Address (Street	· · · · · · · · · · · · · · · · · · ·	Mary L.	City or Town, State,	Zin Code)
and 2 s	W = 0	12.	Sharon Carter)		-			Md. 214	
– ע	Hea tem othe		20a. Method of Disposition		20b.		osition (Name of matory or other place			20c. Location - City or	
Pages	nt: If		1 ABurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		Res	stqate	Memori		7/06 A	nnapolis	Mα
Dalling	ortar injur		21. Signature of Funeral Service		Pai		2. Name and Addre	1			
ă	Depa Impo eny ii		Larry B.	Reeso MC	0489	3 8	m. Rees 21 West	e & So	ns MOrtu nnapolis	ary, P.A , Md. 21	4 01
- 13			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca	used the dea						Approximate Interval Between
PI	nysician		Immediate Cause (Final disease or condition	H	- 16	1 == =					Onset and Death
Si . J	Medical		resulting in death)	a. Dyelo (o	r as a consec	quence of):	1				
E.	xaminer		Sequentially list conditions	, Acut	i R	enal	Pailus	-e			
<i>⊕</i>	=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consec	quence of):	, ,	1	1		
ecute	trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. End	Strys	= 10	almoran	hyp	ertersion		
or ou,	physician and the buriai-transit	<u> </u>	rossing in sealing case	Due to (o	ras a comsec	quence of):	10	7.0			
cate	physi the t	dical	1	d. Cox		almor	AIC.				
Sertifi	ding se as	Physician/Me	IF FEMALE:	23c. If yes, outcome	ome of preon	ancv				201.5.11	
eath eath	atten for u	clan	23b. Was decedent pregnant in the past 12 months?	1 Live bir	th 2 Feta	al death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	Day Year
je č	y the	lysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknov							
The law requires that the death certific	been signed by the attending p should be detached for use as	by Pt	Part II. Other significant condition	ns contributing to dea	th but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
	n sign								12 Ye	s 2 No 3 P	robably 4 Unknown
	shot s	ompleted							24a. Was ar	24b. Were a	utopsy findings available
F e is	cate has I	mo							autops	prior to death?	completion of cause of
	tifical tor, p	C	25. Was case referred to medical					26. Place of D	1 ☐ Yes 2 eath (Check only one	Pro 1 □ Yes	2 No
IVSICI	direc	To B	examiner?	Hospital:	patient 2	ER/Outpatier	nt 3 DOA Oth			nce 6 Other (Spe	ecify)
_ E	ter th		27. Manner of Death	28a. Date of (Month	Injury Day Year)	28b. Time o	f 28c. Injun		28d. Describe ho		
nding 1	or: Af	atlc	2 ☐ Accident investig	gation		,,		Yes 2 □ No			
Y A	irecto	ertification:	3 Suicide 6 Could r 4 Homicide determ	inord 286. Place C	f Injury - At h	nome, farm, sti	reet, factory, office		28f. Location (Str City or Town	eet and Number or R State)	ural Route Number,
عَ وَ	rai Di	O									
To the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	edical	(Check only 2 Medical	g Physician: To the be Examiner: On the bas	is of examina	owledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date and pla- pinion, death oc	ce, and due to the ca	use(s) and manner as	s stated. e to the cause(s)
ş	thin 2	Med	one) 29b. Signature and title of certified	and manne	or stated.		29c. Licensi				
ç	¥ 5 8			1		mp			1	d. Date signed (Mont	
			20 Name and address of	unha complate d		m 02-1 /7	() () () () () () () () () () () () () (> 169) (m 02,	2006
			30. Name and address of person			m 23a) (Type,	on 1	9	1	from Oz,	2 14/1
67F4	Sta	ite	31. Date filed (Month, Day, Year)		gistrar's Sign		1 10	Tung	MUNULLA	1173 MI	2//0/
	Renisti		ARM O S	2006	han a	Oh Con	1000				

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of F		Mental Hy	giene	01418				
			1. Decedent's Name (First, Middle, L	ast)				2. Date of De		3. Time of Death				
и	Physici /Medio		Doris Specto	r Kalman				Januar	y 1, 2006	9:38 A. M				
	Examin		4a. Fecility Name (If not institution, ga	ve street and number)		4b. City, Town, o	Location of Dea	ith	4c. County of De	ath				
			Holy Cross Hosp			Silver			Montgon					
	Funeral			Sex 7. Age 1 ☐ M 2 ☐ F	(In yrs. last birthday)	Months Days	If Under 24 Hr Hours Mir	. (Month, D	ay, Year) (rthplace (State or Foreign Country)				
	Director		Usual Residence of Decedent	X	86 ^{rrs.}			Dec.	20, 1919 Ne	w York				
	yland		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits				
	a-fst	itor	Maryland Montgom	ery	Silver S	oring				1 ☐ Yes 2 ☐ No				
	or 28)ire	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?				
	23a	rai	3701 Internationa	1 Drive, #	753	2090	6		U. S. A.					
	within 72 hours after death with the Maryland ene. than 'natural', or Items 23e or 28e-f show Ite Modical Exerting to ust be rediffed at	by Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of H f Yes, specify Cuba	ispanic Origin? (an, Mexican, Pue	Specify Yes or Norto Rican, etc.)	o- 14. Race - Am Black, Wh					
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married X 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 ZNN If Yes, Give Year or Dates:		1 ☐ Yes 2 📉 No	Specify:		Specify:	White				
Ş	2 hou		15. Decedent's B		16a. Dece	dent's Usual Occup	ation		16b. Kind of Busines	s/industry				
215	nin 7.	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5-	(Give	kind of work done on DO NOT use retired	during most of w	orking						
21,	77 75 15 15	ЩO	12 Years	Obilege (1-401 5	-	nistrativ	e_Assist	tant	U. S. Go	vernment				
ם	be filed ital Hygi d other event, I	Be (17. Father's Name (First, Middle, Las	t)			18. Mother's Na	ame (First, Middle	e, Maiden Surname)					
yla	- C 0	2	Harry Spector					Weiser						
Maryland 21215-0036	es 1 and 2 should of Health and Me fitem 27 is mark rother traumatio		19a. Informant's Name/Relationship							Zip Code) 20906				
	1 and 1 and 1 and 27 3 m 27 3 m 27		Benjamin Kalman 20a. Method of Disposition	- Husband	20b. Place of Dispo		lonal Di	r., # /5. Date	3, Silver S					
Baltimore,	nent of H		1 Bunal 2 □ Cremation 3		cemetery, crer	natory or other plac								
Ē			' 4 □Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		Mt. Leban	non Cemet Name and Addres		3/2006	Adelphi, M	laryland				
Ba	permit. Departr Importa any inju		21. Signature of unional cervice Eco	311300	E	lward Sag	el Fune	cal Dire	ction, Inc. ville, Mary	1 1 00050				
			23a. Part1. Enter the disease, or con	mplications that caused	the death. Do not ent	er the mode of dyin	g, such as cardia	ce, <u>ROCK</u>	VIIIe, Mary arrest,	Approximate				
	Physician		shock, or heart failure. List only one cause on each line. Interval Between Onset and Death											
	/Medical		disease or condition resulting in death)		Respirato	ory Failu	re							
	Examiner		Comment the line and distance		Logenic Sho	ock								
	п ≓	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	Due to (or as a consequence of): Acute Myocardial Infarction									
	icate be executed physician and sthe burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C		ar intarc								
8760,	cate be executed bhysician and the burial-transit	E	Toolaing in doain, East		consequence of):	Fibrilla	tion							
87	physicate sthe	dicai		d										
эх 6	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of de	alivery				
Вох	death e atter	iciai	in the past 12 months?	1□Live birth 2 4□Pregnant at t]Ectopic pregnancy] Other <i>(specify)</i>			Month	Day Year				
Ö.	that the de led by the a detached	Physician/Me	9 Unknown	9□ Unknown										
s, P.	requires that the death certifi seen signed by the attending I hould be detached for use as	by P	Part II. Dther significant conditions	contributing to death bu	t not resulting in the ur	nderlying cause give	en in Part I.	23e. Did 1	tobacco use contribute t	**				
ord	w requires t been signe should be	ted						1 🗆	Yes 2□No 3□P	robably 4 Zilinknown				
မင္ပ	aw Is b	Completed						24a. Was	psy prior to	utopsy findings available completion of cause of				
Vital Records,	(0	Con						perfo 1 ☐ Yes	ormed? death? 2 XNo 1 ☐ Ye	s 2X No				
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	25	eath (Check only						
5		. To	Yes 2 No 27. Manner of Death	28a. Date of Injury		1 3 DOA	4 Nursing		idence 6 Other (Spe how injury occurred	ecify)				
on	tending leath. tor: After the funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	Work	(? Yes 2 □ No	250, 250, 150	now injury occurred					
Division of	or Attending after death. Director: After in by the fune	ifica	3 Suicide 6 Could not	28e. Place of Inju	ry - At home, farm, stre	eet, factory, office			Street and Number or F	lural Route Number,				
Ö	alor As after al Dire	Certification;	4 Homicide	building, etc.	. (Бресіту)			City or To	wn, State)					
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier 1 Certifying P	hysicien: To the best o	f my knowledge, death	occurred at the tim	ne, date and plac	e, and due to the	cause(s) and manner a date and place, and du	s stated.				
	To the H within 24 To the F complete	Jedi	one)	and manner stat	ed.			uned at the time,						
	7 witl	Σ	29b. Signature and title of certifier			29c. License			29d. Date signed (Mon					
	10					B92	860		January 1	, 2006				
			30. Name and address of person who Dr. Carl Margo				ite 211.	Rockvi	lle, Maryla	nd 20852				
	Sta	te	31. Date filed (Month, Day, Year)						, , , , , , , ,					
	Registr		JAN 06	2006	r's Signature	34-54								

Thomas C. Long Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#28e,pen/E, 0853,3/2/06 TT State of Maryland / Department of Health and Mental Hygiene 06-00047 1 - For State Registrar CTCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Christopher Thomas Long P^{M} Jan<u>uary</u> 02 2006 2:18/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6303 White Cove Drive Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 7/29/1954 9. Birthplace (State or Foreign **Funeral** 1 ☐ XM 2 ☐ F Yrs. Director 216-56-9041 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?? is marked other than "netural", or frame 23a or 28a-f ehow traumatic avent, its Medical Examinar must be notified at ¥☐Yes 2 ☐ No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6303 White Cove Drive 21801 USA within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Completed by Specify: white 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2+ Self-employed Process server 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental H Thomas Long ss 1 end 2 should b of Health and Menta item 27 is marked Jeanette Lange 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3760 Old Post Rd., Salisbury, MD 21804 John Andrews/brother-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Dapartment of H
important: if itel
any injury or ott 1 XBurial 2 Cremation 3 Removal from State 1/7/06 Parsons Cemetery Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lian ee 22 Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death shot gun Physician Contact would /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physicien by Physician/Medical ate has been signed by the ettending page 2 should be detached for use as 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performe 1X Yes 2 🗆 No funeral director. 25. Was case referred to medical examiner?

XX Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Mother (Specify) Scene Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. Subject shot set FOULL 1430 1 ☐ Yes 2 👿 No 2006 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28e. Place of Injury At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide At home To the Hospital within 24 hours a To the Funeral C 6303 White , Salisbury cove anive 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME January 3, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. istrar's Signature State JAN 0 9 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene State Registrar Amended item #20a per fh/wick artificate of Death 01-18-2006/dals sion 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JAHUBAY Karen Kay Lynch 2006 01:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cente legional medical WILDMILD If Under 24 Hrs. If Under 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 215-58-7332 1 M 2 X Yrs. Director 54 9/30/1951 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exaction errorat be recitified at 1 ☐ Yes X No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32055 Spearin Rd. 21804 USA death v Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after I ☐ Yes 2 X No f Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White ģ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Real Estate Agent if Health and Mental Hygid Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Kenneth Wesley Kinnamon Margaret Ann Tyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph G. Lynch/husband 32055 Spearin Rd., Salisbury, MD 21804 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: if ite any injury or of grice. Burial 2 Aremation 3 Removal from State 4 Donation 5 Other (Specify) Springhilly Memory Gārdens 1/10/06 Hebron, MD Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Ja 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine led by the attending physicien and detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed relienvy6 that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ate has been signed by pege 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∰ nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 3 ☐ No 1 🗆 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation s effer des. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital o within 24 hours eff To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certified 29c. License numbe 29d. Date signed (Month, Day, Year) mulmer) who completed cause of death (Item 23a) (Type, Print) 30 ame and address of persor 106 Millo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 9 2006 Registrar

			, rot	partment of Health and Ment ertificate of Death	tal Hygiene 006 01421						
	Diversity:		Decedent's Name (First, Middle, Last)		Date of Death Month Day Year 3. Time of Death						
	Physici /Medio		William K. Ledbetter, Jr.	J	anuary 5,2006 12:00AM						
)	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death						
			1603 Aragona Blvd.	Fort Washington y) If Under 1 Year If Under 24 Hrs. 8. D	Prince Georges						
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 225-33-4869 37 Yrs.	Months Days Hours Min.	Date of Birth 9. Birthplace (State or Foreign Month, Day, Year) 9. Birthplace (State or Foreign Country) Virginia						
			Usual Residence of Decedent	pa.	iy 30,1300 viiginia						
	how Let		10a. State 10b. County 10c. City, Town or I								
	Be-f	cto		shington	1 Zves 2 □ No						
	vith th	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?						
	s 23s	by Funeral Director	1603 Aragona Blvd. 11. Marital Status 12. Was Decedent Ever in U.S. 13	20744	Yes or No. 14. Race - American Indian.						
	Item Item	-un	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 2 No	Was Decedent of Hispanic Origin? (Specify North Press, specify Cuban, Mexican, Puerto Rican)	n, etc.) Black, White, etc.						
920	urs af	b	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	Specify: Black						
21215-0036	within 72 hours after deeth with the Maryland ene. than "naturel", or Items 23s or 28e-f ehow the Madical Examinar must be notified at	sted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation	16b. Kind of Business/Industry						
2	athin 76.	Elementary/Secondary (0-12) College (1-4or 5+)									
12	led w tygier her th		12 Mai	ntenance	Apartment Complex st, Middle, Maiden Sumame)						
anc	d be f	To Be	William K. Ledbetter, Sr.		abeth Bigsby						
Maryland	12 should be filed within 1 h and Mental Hygiene. 7 is marked other than "r reumatic event, the Med	ř		iling Address (Street and Number or Rural Rou							
N	alth ar		19a. Informant's Name/Relationship (Type, Print) Mother 19b. Mai 160	3 Aragona Blvd.,F	t. Washington, MD 20744						
ore,	of Hear fitem		20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 20b. Place of Disposition	ematory or other place)	20c. Location - City or Town, State						
Ĭ	Pag ment ent: i			ematory or other place) Ory 1/6/20	006 Alexandria, VA						
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene was proportent: if item 27 is marked other than "nature; or Items 23a or 28a-f show amportent: if item 27 is marked other than "nature; or other traumatic event, the Medical Examinar must be notified at ODCs.		21. Signature of Funeral Service Licensee 22. Name and Address of Facilin Greene Funeral Home, I 814 Franklin Street-Alexandria, VA 2								
	1000		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or resp	Interval Between						
	Physician		Immediate Cause (Final disease or condition a. A c quire d	Immunodeficie	ency Syndrone Onset and Death						
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	////							
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	$\sigma \sim$							
	cate be executed physician and the burial-transit	Examiner	that initiated events								
0,	iaw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):								
8760,	physic the bu	dical	d								
39 x	ding page as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		201 011 111						
Вох	leath certifica attending ph I for use as t	clan	in the past 12 months?	BEctopic pregnancy Other (specify)	23d. Date of delivery Month Day Year						
O.	that the de ed by the detached	Physician/Med	1 Yes 2 No 4 Fregnant at time of death 5 9 Unknown								
Ф,	res that igned b	by Pl	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobacco use contribute to the cause of death?						
rds	quire an sig	ed b	Grabetes Mellitus	- 11	1 Yes 23 No 3 Probably 4 Unknown						
Records	law requ as been 2 should	Completed		2	24a. Was an autopsy findings available prior to completion of cause of						
	The law	Com		1	performed? death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No						
Vital	icien: Th certificate ector, pag	Be (25. Was case referred to medical examiner?	26. Place of Death (Che	eck only one)						
of	hys this al dir	2	1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpati 27. Manner of Death 28a. Date of Injury 28b. Time		5 Residence 6 Other (Specify)						
nc On	fter	Hon	1 Natural 5 ☐ Pending (Month, Day Year) Injury		Describe how injury occurred						
Division	Attending r death. ector; After y the fune	fica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, s	street, factory, office 28f. L	_ocation_(Street and Number or Rural Route Number,						
ō	el or safter	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, State)						
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)											
	To The	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)						
	(3)		B. Sinvase	MD 30458	01/05/2006						
	MC		30. Name and address of person who completed cause of death (Item 23a) (Type BETJENKI. S. CHBRY M.D.	e, Print) 6 2 ving, stre	01/05/2006 cet, NW, Suite - 309 m DC - 20010						
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	wasning 10	n V - 20010						
	Regist		JAN 0 6 2006 Bleave & Amel								

DHMH 17 Rev 1/2001

		,	1 - For State Registrar	State	of Marylar	•	artmeni rtificate				_	giene Reg. No	006	014	22
	Diam'r.		1. Decedent's Name (First, Middle, Li	ast)							2. Date of De Month	ath Day	Year	3. Time of	Death
	Physici /Medio		Barbara Ann I	ippy							January	7 10	2006	0814	М
	Examir	er	4a. Facility Name (If not institution, gi		mber)				Location				nty of Death		
	/		10836 Repp Road				Un:		Bridg				rederi		
	Funeral			Sex 1□M 2□F	7. Age (In yrs.	50 Yrs.	Months	Days	Hours	Min.	8. Date of Bir Month, Da Apr 1	7 1955	9. Birth	place (State or intry) MD	Foreign
	Director		Usual Residence of Decedent	Λ.	<u> </u>	50					1.45-1	. 2300			
	land iow		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							10d. Inside Cit	y Limits
	Mar 9-fat	tor	MD Fre	derick		Union	Bridg	e						1 Tes	2 № No
	or 28	Director	10e. Street and Number				10f. Zip					10g. Citizen		intry?	
	23a		10836 Repp Road	i 				2	1791			U	SA		
	de se de se	Funeral	11. Marital Status	Armed Fo		J.S. 13.	Was Deced	lent of Hi	spanic Ori n, Mexicar	gin? (Spe 1, Puerto	cify Yes or No Rican, etc.)	- 14. F	Race - Amer Black, White		
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Gi Year or D	ve	1 ☐ Yes 2 ☐ No Specify:						Spe	city: Wh	nite	
8	n 72 hours after death with the Maryland "natural", or Itama 23a or 28e-f ahow idical Exarcher must be notified at	ed	15. Decedent's E		74163.	16a. Dece	dent's Usua	I Occupa	ation			16b. Kind o	f Business/li		
15	-	plet	(Specify only highest g	ade completed)	1 4 5 -)	(Give	kind of wor DO NOT us	k done a	lurina mos	t of worki	ng	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,	
212	filed within Hygiene. other then "	Completed	Elementary/Secondary (0-12)	College (1-40r 3+)	Н	iomema	ker				Ow.	n Home	=	
פ	be filed withintal Hygiene. Ind other then avant, the M	Bec	17. Father's Name (First, Middle, Las								(First, Middle		name)		
<u> a</u>	2 should be filed within and Mental Hygiene. Ia marked othar than aumatic avant, Tie M	2	Donald Leroy Ste	ephan, S	Sr					aura	Amanda	CIICK			
Maryland 21215-0036	2 should and Men la marke aumatic		19a. Informant's Name/Relationship			1					I Route Numb			_	
	s 1 and 2 f Health item 27 l		Cletus Lippy/hus	sband	l non			-			on Brid				
Baltimore,	Pages nent of int: If if		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from	Cara	Place of Dispo cemetery, crer Meadow	matory or or	ther place	θ)		12 006		on - City or T +minst	own, State cer, MD	
ţ			4 Donation 5 Other (Spec		P				- 1	_				XI, ID	
Bal	Departr Departr Imports any Inju		21. Signature of Funeral Service Licensee Printer of Funeral Service Licensee 412 Washington Road Westminster, ME											21157	
			23a. Part Lenter the disease, or con shock, or heart failure. List only	nplications that of one cause on o	caused the dea each line.	th. Do not ent	er the mode	e of dying	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Betwonset and D	neev
	Physician		Immediate Cause (Final disease or condition	_ a ('	outac	+ Gui	usho	+ u	our	d to	Neck			Oriset and D	eatn
	/Medical Examiner		resulting in death)		(or as a consec			17							
	_xaniii.e.		Sequentially list conditions,	b. ——————	(Ul da a Collago										
	nsit	Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	xar	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):									
8760,	sicier suri			. d											
89	ificate g phys as the	edic										- 1			
Вох	eath certific attending p for use as f	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant		itcome of pregn		Tetonione					23d.	Date of deliv	ery	
œ.	death e atte	lcla	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of		Ectopic pro Other (sp.						Month	Day Y	ear
P.0	that the de ted by the detached	Å.	9 DUnknown	9CI ONK	IOWII										
Ś	peugi pe de	þ	Part II. Other significant conditions	contributing to d	leath but not re	sulting in the u	nderlying ca	ause give	n in Part I	•		V		the cause of de	
Vital Records,	v requir been s should	Completed							_		10	Yes 2. ☑No	3∐ Pro	bably 4 □U	nknown
e C	e law r has be re 2 sh	를									24a. Was autor	osy	prior to co	opsy findings a	vailable use of
		5									1 Tes	rmed? 2 ☐ No	death?	2 🗆 No	
/ita	ician:] certifical rector, p	Be	25. Was case referred to medical examiner?	Hospital:				01-		of Death	(Check only o	one)			
o	Q in	2	Yes 2 No 27, Manner of Death	10		ER/Outpatier 28b. Time of			4 140		me 5 Resident			_{b)} Scene	<u> </u>
	ding After	lo	1 □Natural 5 □ Pending		of Injury oth, Day Year)	Injury a	- / M	8c. Injury Work	res 2.2X.		28d. Describe	och c	l i e	011	
isi	ten leatl tor: the	lca	2 Accident investigation 3 Suicide 6 Could not	De Diag	0-06 e of Injury - Ath		*AM		.00 2/2		28f. Location	Street and Nu	mber or Bur	al Boute Numt	ner
Division	i Diffe	Certification;	4 Homicide determine	build	ling, etc. (Speci	idence		, 011100			City or To	vn, State) [\$36 B	Repp Ro	1
_	ospital or A hours after uneral Dire ly filled in b		29a. Certifier 1 ☐ Certifying F	hysician: To the	e best of my kn	owiedge, deati	h occurred :	at the tim	e, date an	id place,	and due to the	cause(s) and	manner as	stated.	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	one) XIX Medical Ext	miner: On the t	pasis of examination of stated.	ation and/or in	vestigation,	in my op	oinion, dea	th occurr	ed at the time,	date and place	e, and due t	o the cause(s)	
	within To th comp	Me	29b. Signature and title of certifier				29c	License	number			29d. Date siç	ned (Month,	Day, Year)	
	N		I Canol Ha	llan	ud			OCME January, 10, 2006							
	かった		30. Name and address of person who	completed cau	se of death (Ite	m 23a) (Type,			10						-
	,		CAROLHA	upu	nie		111	l Pei	nn St	reet	Balti	more,	Maryl:	and 212	.01
	Sta		31. Date filed (Month, Day, Year)		Registrar's Sign		/								
2	Registi	ar	JAN 1 2	7000	ilvere	15. 1	mark	1							

			1 _ State	State of Ma	ryland / Dep		of Health and N	lental Hygi	iene g. No. 2006	01423	
			Registrar 1. Decedent's Name (First, Middle, Last)			on initial or	5, <u>5</u> 04.,	2. Date of Deat		3. Time of Death	
	Physici	an		oin				Month January	Day 2006	9:25A. M.	
Can y	/Medic		Nita Levin-Epst 4a. Fecility Name (If not institution, give s			4h City Tow	vn, or Location of Death		4c. County of Dea		
	Examir	er	Holy Cross Hosp				er Spring	Montgom			
			5. Social Security Number 6. Sex		(In yrs. last birthda						
	Funeral Director			M 2 F	80 Yrs.		ays Hours Min.	(Month, Day,	9. Bir Co 1925 Nev	ountry)	
			Usual Residence of Decedent	21				Har. 50	, 1525 110	W IOIK	
	land		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits	
	Mary	ţ	Maryland Montgome	rv	Silver S	Spring				1 ☐ Yes 2 ☐ No	
	128a	rec	10e. Street and Number			10f. Zip Co	de	10	0g. Citizen of What Co	ountry?	
	3a o	0	13904 Bethpage Lar	ıe		2	0906		U.S.A	•	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ehow ha Moulcal Examitical mast be notified at	Funeral Director		2. Was Decedent B	Ever in U.S. 13	3. Was Decedent	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame		
က	or ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 XN If Yes, Give	o		No Specify:	nican, etc.)	Black, Whit	White	
8	ours o	b	3 Widowed 4 Divorced	Year or Dates:		ILITES ZUAL	[NO <i>Зресну</i> .		Specify:	wiitte	
21215-0036	72 hc	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dec	edent's Usual O	ccupation fone during most of work etired)	king	16b. Kind of Business	/Industry	
2	thin a	n d	Elementary/Secondary (0-12)	College (1-4or 5	+)						
21	ygien Fr. II.	S		5+	So	ocial Wo			Social W	ork	
P	d oth	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, M			
yla	Men Men arke	ဥ	LAZAR NONIN					Grosfeld			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Modical Examination and 2006.	13	19a. Informant's Name/Relationship (Ty) Michael Levin-Epst						-		
	and lealth m 27 her t										
9	H of H	1	20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ R	emoval from State	20b. Place of Dis cemetery, ci				·		
Baltimore,	Pag ment:		4 □Donation 5 □Other (Specify)			Memoria				YLAND	
3a	Departimon important in portant i		21. Si natura of Funeral Service License	90	1	22 Name and A EDWARD S	ddress of Facility SAGEL FUNERA	AL DIRECT	TION, INC.		
ш	20 E S 8		Jun 19			1091 ROC	KVILLE PIK	E, ROCKVI	LLE, MD	m, State, Zip Code) aryland 20878 n - City or Town, State MARYLAND NC • MD 20852 Approximate Interval Between Onset and Death	
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	est,	Interval Between						
1	Physician		Immediate Cause (Final disease or condition	RESPIRAT	ORY FAILU	JRE				Olisot and Doam	
	/Medical		resulting in death)	Due to (or as	a consequence of):						
	Examiner		Sequentially list conditions		BRAIN INJU	JRY					
	D #	Examiner	fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	-	a consequence of):						
	ecute and -tran	cam	that initiated events resulting in death) Last		JLMONARY A a consequence of):	ARREST					
760,	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	E		200 (0) 43	a consequence on.						
87(cate b	dical		l							
89 x	certificat Iding phy Ise as th	₩.	IF FEMALE:	3c. If yes, outcome	of oregnancy				20.1 D.11.1-	45 ==	
Вох	ath c	lan	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregr			23d. Date of de Month	Day Year	
_	the s	ysic	1 ☐ Yes 2 🔯 No 9 ☐ Unknown	9☐ Unknown	ume or death :	5 ☐ Other (specif) //				
P.0.	requires that the een signed by th nould be detache	F.	Part II. Other significant conditions cor	tributing to death be	ut not resulting in the	underlying caus	se given in Part 1.	23e. Did tob	pacco use contribute t	o the cause of death?	
ds,	S C 0	b b	EMPYEMA PRIOR DECOR	TOTTON.	ANVIETV	מסדת חוא	FCCTON.	1 □ Y€	s 2 No 3 P	robably 4 ⊠Unknown	
Ö	w require been signal	ete		,			,	24a. Was a	a Jah Mora a	utana findinas available	
Vital Records,	e la has	Completed by Physician/Med	HYPERTENSIVE CARDIC	MYOPATHY	WITH DIAS	STOLIC D	YSFUNCTION	autops	y prior to death?	utopsy findings available completion of cause of	
a F	. 60 07		ATRIAL FIBRILLATION	; HYPERL	IPIDEMIA_			1 ☐ Yes 2	2 X No 1 ☐ Ye	8 2□ No	
Z.	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	lospital: V			Other	th (Check only on			
ō	Phys this ral di	2	1 ☐ Yes 2 ☒ No	141 Inpatie	nt 2 ☐ ER/Outpat		4 Nulsing ti		ence 6 Other (Specow injury occurred	ecify)	
5	Jing After fune	Sign	1 X Naturat 5 ☐ Pending	28a. Date of Inju	Year) Injur	y M	Injury at Work? 1 ☐ Yes 2 ☐ No		,,		
Si	uttendi death. ctor: A y the fu	Ica	3 Suicide 6 Could not be	28e. Place of Inju	ury - At home, farm,			28f. Location (St	reet and Number or R	ural Route Number,	
Division of	after Dire	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)	,,		City or Town	n, State)		
_	lospital I hours a unerel [O	29a. Certifier 1X Certifying Phys	sician: To the best	of my knowledge, de	eath occurred at t	the time, date and place	, and due to the ca	ause(s) and manner a	s stated.	
		Medical	(Check only 2 Madical Exami	ner: On the basis of and manner sta	examination and/or	investigation, in	my opinion, death occu	rred at the time, d	ate and place, and du	e to the cause(s)	
_	To the within 2. To the decomplet	Me	29b. Signature and title of certifier			29c. L	icense number	2	9d. Date signed (Mon	th, Day, Year)	
	1		* X T. (C)	Mi-	M		D36252		JANUARY 3	, 2006	
	Y		30. Name and address of person who co	ompleted cause of d	eath (Item 23a) (Tyc	oe, Print)					
			STEVEN T. KARIYA, N				, WHEATON,	MD 2090)2		
	St	ate	31. Date filed (Month, Day, Year)		ar's Signature						
	Regist		JAN 0 6 20	06	JJ A						

DHMH 17 Rev 1/2001

		1	For State Registrar	State of Mar	-	artment of H			ene g.No.006	01424	
			1. Decedent's Name (First, Middle, Last	7)				2. Date of Death Month		3. Time of Death	
	Physicia /Medic	A	George J. Lewis					January			
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deat	h	4c. County of		
			9048 Bowie Road			Nanjemoy		(8:4)	Charles		
	Funeral		5. Social Security Number 6. Se	DM 2□F	In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year)	Birthplace (State or Foreign Country)	
	Director		238-40-6484 Usual Residence of Decedent	81	110.			Aug. 31	, 1924 1	North Carolina	
	land ow		10a. State 10b. County	1	0c. City, Town or Lo	cation				10d. Inside City Limits	
	Many P-f sh	ģ	Maryland Charles		Nanjemoy					1 ☐ Yes 2 XNo	
	r 28¢	Funeral Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	at Country?	
	th wit	a	9048 Bowie Road			20662	2		U.S.A.		
	dea	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)		American Indian, White, etc.	
9	or it	F.	1 ☐ Never Married 2 ☐ Married	1 X Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		Specify:		
8	72 hours after death with the Maryland natural; or itams 23a or 28e-f show Jisal Evanniner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:		dent's Usual Occupa	tion		6b. Kind of Busin	Black	
7	n 72 •nat	ete	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	kind of work done a DO NOT use retired,	luring most of wo	rking	Ob. Kind of Busin	nessmoustry	
21215-0036	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ehouse Lak	oorer		U.S. Gov	vernment	
	e filed Il Hygie other vant,	Be C	17. Father's Name (First, Middle, Last)					me (First, Middle, M	faiden Sumame)		
lan	should be and Mental marked c		James Pate Lewis				Leora	Davis			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Health and Mental Hygiene it is marked other than "netural", or itams 23a or 28e-f show itam 27 is marked other than "netural", and it is marked or collined at other traumatic event. The Medical Examiner must be notified at		19a. Informant's Name/Relationship (7	ура, Print)		•		ural Route Number,		ate, Zip Code)	
	1 and 2 Health am 27 i		Shannon P. Jackson	Daughter			ad, Nanj	emoy, Md.			
ore	0 0	1, 3	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, cres	natory or other place	^{e)} Jan. 10	.2006	20c. Location - Ci	ity or Town, State	
Ĕ	Pages ment of lant: if it		° 4 ☐ Donation 5 ☐ Other (Specify)	Mount Hor	oe Baptist	t Church	N	ianjemoy	, Maryland	
Baltimore,	permit. Pag Department Important: i any injury o		21. Signature of Funeral Service Licen-	ling 1	M00668 W	Name and Address illiams Fi 270 Hawth	uneral H orne Roa	ome, P.A. d, Indian	Head,	Md. 20640	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the	e death. Do not ent	er the mode of dying	g, such as cardia	c or respiratory arre	est,	Approximate Interval Between	
	Physician	N 1	Immediate Cause (Final disease or condition	a au	revosale	rolic Ca	ndiov	ascula	diseas	Chiset and Death	
1	/Medical Examiner		resulting in death)	Due to or as a	consequence of):						
ů.		-	Sequentially list conditions,	b. Due to (or at a	Old Lines	on				-	
	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	77							
	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):						
8760	death certificate be executed e attending physician and of for use as the burial-transit		· ·	d							
89	tificat ig phy as th	Physician/Medical									
ŏ	leath certifics attending ph d for use as the	N/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		Ectopic pregnancy			23d. Date		
. B	deat deatt	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tir 9☐ Unknown		Other (specify)			Month	n Day Year	
P.0	law requires that the de as been signed by the a 2 should be detached	Phy	9 Unknown Part II. Other significant conditions co	entribution to don't but	not reculting in the u	andorhina onusa anu	on in Part I	23a Did tob	acco use contrib	ute to the cause of death?	
S,	res tha signed I be de	by	Part II. Other signmeant conditions of	Stitlibuting to death but	not resulting at the t	inderlying cause give	sit iii r ait i.			☐ Probably 4 ☐ Unknown	
ecords,	w require been si should I	eted									
Rec	e law has b	Completed						24a. Was ai autops perforn	y pri	ere autopsy findings available or to completion of cause of ath?	
alF	ilcian: The t certificate ha rector, page							1 Tes 2	No 1	Yes 2 No	
Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3 DOA Othe	o.p.	ath (Check only on Home 5 Reside		(Enocyty)	
of		H-:	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c, Injury	v at	28d. Describe ho			
On	Attending Ph r death. ector: After th by the funeral	tlor	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	Ye <i>ar)</i> Injury	Worl M 1 □	k? Yes 2 □ No				
Division	i or Attendi after death. Director: A	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, st	reet, factory, office		28f. Location (St. City or Town		or Rural Route Number,	
Ö	ospitai or A hours after unerai Dire ly filled in b	Certification:	4 Hornicide	ballaling, etc.	(Specify)			. Only or round			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical		ysicien: To the best of niner: On the basis of e and manner state	xamination and/or in						
	To th Within To th	Me	29b. Signature and title of certifier	1/1/2		29c. License	e number	25	9d. Date signed ((Month, Day, Year)	
			\)(/	HOUR])22	574		1/6/9	00	
(4		30. Name and address of person who	com leted cause of dea	ath (Item 23a) (Type	Print)				20604	
d	B291		K.TIMOTHY D	ACE , M	1,0, 120	070 OLB	LINK C	CHITTER	WALK	och Ma.	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JAN 0 6	2006 32. Registrar	's Signature	porte					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Vera C. Lowther 2006 January 3:05P.M. /Medical 4e Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Daath 4c. County of Deeth **Examiner** Prince George's Hospital Center Cheverly Prince George's If Under 24 Hrs. 8. Date of Birth Month Dey Year) May 17, 1928 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 1 Year 9. Birthplace (State or Foraign 6. Sax **Funeral** Days Hours 1 ☐ M 2 💢 F 77 Months Yrs. Washington, D.C. 220-26-6835 Director Usuel Rasidanca of Decedent death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f sho traumstic event, the Madical Examiner must be notified at Prince George's Maryland Cheverly 1 X Yas 2 □ No Director 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 2900 Mercy Lane 20785 United States Funeral 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decadant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Giva 14. Race - American Indian. 11. Maritel Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of haufth and Mental Hygiene.
ant: if item 27 is marked other than "natural", or itellially or other traumatic event, I'm Modical Examinativy or other traumatic event, I'm Modical Examinativy. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: • White Specify. þ 3 ₩ Widowad 4 Divorced Completed 16a. Dacedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamentery/Secondary (0-12) College (1-4or 5+) Bookkeeper Retail 18. Mother's Nama (First, Middla, Maiden Surname) 17. Fether's Neme (First, Middla, Last) Ferdinand С. Beckert Mary Elsie Brown 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Numbar or Rurel Route Numbar, City or Town, Stata, Zip Code) Michael Beckert -son 400 E. 55th Street, #3-F. New York, New York 10022 20b. Place of Disposition (Nama of cemetery, cremetory or other place) 20e. Method of Disposition

1△ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Department of important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 1/13/2006 Suitland, Maryland Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 disaase, or complications that caused the deeth. Do not entar the mode of dying, such as cardiac or respiratory arrast, art failura. List only one cause on aech line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) · ARTERIOSCIENTE CANDIOVASCULAR YRANS Examiner Dua to (or as a consaquance of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed bunal-transit Sequentially list conditions, if eny, leading to immadiata cause. Enter Underlying Cause (Disaase or injury that initieted events resulting in death) Last Dua to (or as a consequance of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequance of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Dld tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Tes 2 No Be Completed by 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24a. Was en autopsy Ventilator Dependent (exebral Infanction 1typertension 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was cesa raferred to medical examiner? 26. Place of Deeth (Check only ona) Hospital: 1 Inpatiant Other: 4☐ Nursing Home 5☐ Residanca 6 ☐ Other (Spacify) 1 ☐ Yas 2 No 2 ER/Outpatient 3 □ DOA Medical Certification: To this 27. Manner of Daath 28c. Injury at Work? 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describa how injury occurred 5 Pending investigation 1 Naturel aftar death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accidant filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 4 Homicida 24 hours a 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Cartifier To the Hosp within 24 hou To the Fune completaly fi and mennar steted. 29b. Signature and title of certifier 29c. Licansa numbar 29d. Date signed (Month, Day, Yaar) unellen 30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

ORE MU 4230

32. Registrer's Signatura

1

2006

31. Date filad (Month, Day, Year)

JAN 2

PUKTUS SUNY NO HYGETTS, 110 MID 20189

		س	1- State of Maryland / Department of 26 per verb 4851 01 / Registrar 1. Decedent's Name (First, Middle, Last)	25/06dhi Death	2. Date of Dea	th	J 6	3. Time of Death
	Physici /Medi		Richard Stanley Miller		Month 01	07 2	Yeer 2006	1749 M
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town,	or Location of Death		4c. County		
			Chester River Hospital Center Chester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year			Ken		
	Funeral Director		5. Social Security Number 6. Sex 117-34-1230 15 Months Days Usual Residence of Decedent		8. Date of Birth (Month, Day 10/06	, Year)	9. Birthp Coul	place (State or Foreign ntry) NY
nyfand	show	_	10a. State 10b. County 10c. City, Town or Location Rock Hall				1	IOd. Inside City Limits
the M	28a-f	ecto						1 ☐ Yes 2 🖾 No
th with	23e or	ai Dir	101.25 0000	1661	1	log. Citizen of	USA	ntry?
1215-0036 within 72 hours after death with the Maryland	it of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23e or 28a-f show or other treumatic event, the Medical Examonar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of If Yes, specify Cut If Yes, Specify Cut I □ Yes 2 ☒ No		ecify Yes or No- Rican, etc.)		ce - Americ ck, White, fy: Whi	etc.
21215-0036 d withIn 72 hours af	nen "natur a Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of work ad)	ing	16b. Kind of B		
N B	Hygier other th		5+ Chemical Engi	Ineer	/Eirst Middle	Defens		lustry
/lanc	and Mental Hygiene. Is marked other then eumatic event, the Me	To Be	Stanley Christopher Miller	Norma		viaiden Sumar	ne)	
;, Maryland and 2 should be file	alth and h	1	19a. Informant's Name/Relationship (Type, Print) Brett C. Miller/son 19b. Mailing Address (Stree	tand Number or Rura l., Odento	n, MD	City or Town,	, State, Zip	Code)
Baltimore, permit. Pages 1 a	permit. Pages 1 and 2 Department of Health s Importent: If Item 27 Is any injury or other tre 2002.	The state of the s	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 □ Donation 5 □ Other (Specify)	ice)		20c. Location - Stevens	-	
Balti permit.	Departm Importe any inju		21. Signature of Funeral Service Licensee 22. Name and Addr. Fellows, Fell	Helfenbein	& Newna	ım Fune	ral F 2162	
1	ysician Medical caminer		23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dyi shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	ing, such as cardiac o	or respiratory arre	est,		Approximate Interval Between Onset and Death
8760, cate be executed	physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):					
O. Box 6.	by the attending pt ached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	у			te of delive	ry Day Year
ords, P	been signed I should be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gr	ven in Part I.	23e. Did tob			e cause of death? ably 4 DUnknown
	ate has page 2	Completed			24a. Was ar autops perform 1 Yes 2	y ned?	prior to cor d <u>ea</u> th?	csy findings available npletion of cause of
of Vital Physician: T	certificate rector, pag	Be	25. Was case referred to medical examiner? 1 Types 2 No. Hospital: 1 Types 2	26. Place of Death	(Check only one	9)		
Phy Of	ofter this uneral di	ion; To	27. Manner of Death 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Wo	ry at rk?	ne 5 Reside 28d. Describe ho			7)
Division or Attending	ifter deat Director: in by the	Certifications	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide determined long farm, street, factory, office building, etc. (Specify)	Yes 2 No	28f. Location (Str City or Town	reet and Numb , State)	er or Rura	Route Number,
Hospitel	within 24 hours a To the Funerel I completely filled	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the till a company of the company of	me, date and place, a opinion, death occurre	and due to the ca ed at the time, da	use(s) and ma ite and place, a	inner as stand due to	ated. the cause(s)
To the	within 2 To the complet	Me	29c. Licego)006036	_	d. Date signed	d (Month, L	Day, Year)
12)	Set.s		30. Name and address of person was completed caus of death (Item 23a) (Type, Print)	Rs a	प्रकराया विकास	Bum	Ass	21620
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registral Signature JAN 0 9 2006					

			1 - For State Registrar	State of N	Maryland		artmen <i>rtificate</i>			and M		giene Reg. Nó.	06	01427
	Physici	an	Decedent's Name (First, Middle, ROBERT B MO								2. Date of De	0.	.006	3. Time of Death 05:45 AM
	/Medic Examir		4a. Facility Name (If not institution, CHESTER RIVER H	give street and number			4b. City,		Location o		JANOR	4c. Count		03:43 A.
	Funeral Director		5. Social Security Number 219-03-6517 Usual Residence of Decedent	6. Sex 7 1 ☑ M 2 ☐ F	Age (In yrs. las	ot birthday) Yrs.	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day, Year) APRIL 8, 1919			place (State or Foreign htry) DE
	ne Maryland 8a-f ahow puffied at	Director	10a, State 10b, County MD KENT		, ,	Town or Lo							1	0d. Inside City Limits 1 ☐ Yes 2 X No
	th with the		10e. Street and Number 101 MORGNEC R	OAD			10f. Zip	Code 1620				10g. Citizen of USA	What Cour	ntry?
980	be filed within 72 hours after death with the Maryland nia! Hygiene. et other than "natural", or Itams 23a or 28a-f ahow avant, the Mcdical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decede Armed Force of 1 TYes 2 If Yes, Give Year or Date:	s? ⊒No		Was Deced if Yes, spec 1 ☐ Yes 2	ify Cubar	spanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		ce - Americ ck, White, y: WH	
Baltimore, Maryland 21215-0036	e filed within 72 h al Hygiene, other then "natu vant, Ine M. cical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12			(Give life. :	dent's Usua kind of wor DO NOT us FETY	k done d e retired)	uring most	of worki	ng	16b. Kind of B	usiness/In	•
land	uld be filed Jental Hygi rked othar tic avant, I	To Be (17. Father's Name (First, Middle, L ROBERT MORGAN	ast)							(First, Middle, ENNETT	Maiden Sumar	ne)	
Mary	ges 1 and 2 should be it of Health and Mental if itam 27 la marked o or othar traumatic avi		19a. Informant's Name/Relationshi								ALL, MI	er, City or Town, 21661	State, Zip	Code)
imore,	permit. Pages 1 and Department of Heali Important: If itam 2 any injury or other once.		20a. Method of Disposition 1 □ Burial 2 【ACremation 3 1 □ Donation 5 □ Other (Sp.		te cerr	netery, crer	sition (Nam natory or of KE CR	her place			/2006	20c. Location STEVENS		
Ball	permit Depart Import any in		21. Signature of Funeral Service L	Halfen	bein		ELLOW:	Addres HI EER I	ELFEN ROAD,	BEIN CHE	& NEWN STERTOV	NAM FUNE VN, MD 2	ERAL I	HOME, P.A.
	Pnysician /Medical Examiner	resulting in death) Du to or as a consequence of): Sequentially list conditions b.									r respiratory ar	rest,		Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Externally many Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequer as a consequer									
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal de at time of deat	eath 3	Ectopic pre	egnancy ecify)					te of delive nth	ry Day Year
rds, P	w requires that been signed t should be det	by	Part II. Other significant condition	s contributing to death	but not resulti	ng in the ur	nderlying ca	iuse givei	n in Part I.		23e. Did to	_	ribute to th 3 □ Prob	e cause of death?
al Record	ysician: The law requis certificate has been director, page 2 should	Completed										med?	orior to cor death?	osy findings available inpletion of cause of
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Division of	To the Hospital or Attanding Phwitin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Sertification:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place of I	njury - At home etc. (Specify)	e, farm, stre				-	8f. Location (S City or Tow	Street and Numb n, State)	er or Rura.	l Route Number,
	To the Hospital or within 24 hours after To the Funaral Dirticompletely filled in it	Medical C	29a. Certifier (Check only one) Certifying	Physician: To the best kaminer: On the basis and manner	of examination	edge, death n and/or inv	occurred a restigation,	it the time in my opi	e, date and nion, deatl	place, a	nd due to the o	cause(s) and ma date and place,	nner as st	ated. the cause(s)
(within 2 To the comple	Σ	29b. Signature and title of contriler	Mul	F		29c.	License		03	01	29d. Date signed	106	
1	gratis		30. Name and address of person w	Completed cause of	MD	199	S/L	ZN	RD	2	\$52	afden	·N	D
\$ 5. 4	Sta Registr		3V. Date filed (Month, Day, Year) JAN	1 1 2006 Regis	strar Signatur	م الله	M	rete	7					

			1 - For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of rtificate o		-	giene 006	01428		
			Decedent's Name (First, Middle, Las	t)				2. Date of De	eath	3. Time of Death		
	Physic /Medi		DEVOLIA		MAJETT	E		JANUA	RY 02, 200	1.1		
	Examir		4a. Facility Name (If not institution, give			4b. City, Town	, or Location of De	ath	4c. County of Death			
			ARCOLA HEALTH AN				LVER SPRI		MONTG			
	Funeral Director		5. Social Security Number 6. Se 579 40 4960 Losual Residence of Decedent	M XXF 7. AG	ge (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Day			ay, Year)	Birthplace (State or Foreign Country) SHINGTON, DC		
	show		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits		
	e Mar	ctor	MD PRINCE	GEORGES	UPPER M	ARLBORO				1 ☐ Yes 2XXXNo		
	or 28	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of What			
	s 23s	ra	9806 STONEWOOD C		E 1110	2077			UNITED S'			
21215-0036	be filad within 72 hours after death with the Maryland nat Hygiene. Id other than "naturel", or Itams 23s or 28s-1 show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married XX Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes ※XX If Yes, Give Year or Dates:	No	Was Decedent of the Yes, specify Cu	ıban, Mexican, Pue	(Specify Yes or No arto Rican, etc.)	Specify: B			
5-0	72 ho	Completed	15. Decedent's Edi (Specify only highest grad	ication	16a. Dece	dent's Usual Occ	supation ne during most of w	orkina	16b. Kind of Busines	ss/Industry		
21	vithin ne. han "	mple	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use reti	red)		GODDARD			
	filad with Hygiene. Ithar thar		17. Father's Name (First, Middle, Last)	2 YRS	. PHOTO	O COPY I	ECHNICIA		FLIGHT (CENTER		
anc	d be fantal h) Be							, Maiden Sumame)			
Z	2 should be i and Mental I is marked o sumatic eve	은	JAMES ROUNTREE 19a. Informant's Name/Relationship (T.	vpe. Print)	19b. Maili	ng Address (Stre		MYRTLE H	er, City or Town, State	Zin Code)		
Baltimore, Maryland	1 and 2 Health a tam 27 is	1 2	BARBARA ANN ASAN 20a. Method of Disposition		HTER 14514 20b. Place of Dispo	4 MEDWIC	K ROAD		ARLBORO, MI	20774		
	00-		XX Burial 2 Cremation 3 1			natory or other p	, I	1 /6 /2005				
alti.	그 돈 없 글	1	21. Signature of Funeral Service Licent		WASHINGTO							
ä	Depar Impo any ir	6 6	NA Y Wars			MARSHAL	L'S FUNE ITLAND R	RAL HOME OAD SIII	OF MARYLAI	ND, INC. 20746		
	Prysician		23a. Part VEnter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final		Approximate Interval Between Onset and Death							
	/Medical		disease or condition resulting in death)	α	a consequence of):							
ы	Examiner		Sequentially list conditions,	b								
	po tis	iner	if any, leading to immediate cause. Enter Underlying that initiated events		a consequence of):							
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to for as	a consequence of);							
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687	phys phys s the	dical		d								
O. Box (he death certificate be executed the attending physician and ched for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes XXNo 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of del Month 23d. Date of del Month 4 Pregnant at time of death 5 Other (specify)							lelivery Day Year		
	that the led by th detache	/Ph	Part II. Other significant conditions co	ntributing to death b	ut not resulting in the u	nderlying cause g	given in Part I.	23e. Did to	obacco use contribute	to the cause of death?		
rds	requires een sign nould be	d by						1 🗆 Y	Yes X2X∏ No 3 🗆 I	Probably 4 Unknown		
Record	law requir as been si 2 should l	ompleted						24a. Was	an 24b. Were	autopsy findings available		
Re	: The la icate has ; page 2	mo						autop	osy prior to rmed? death?	completion of cause of		
	sician: certifica rector, p	Se C	25. Was case referred to medical				26. Place of De	1 ☐ Yes eath (Check only o		35 2 140		
of V	d is	To B	examiner? 1 ☐ Yes XXX No	fospital: 1 ☐ Inpatie	ent 2 ER/Outpatien	t 3 DOA		4	dence 6 Other (Sp	pecify)		
			27. Manner of Death XXNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time of Injury	28c. lnj W			now injury occurred			
sio	tan leat tor: the	catl	2 Accident investigation 3 Suicide 6 Could not be			M 1	□Yes 2□No					
á	al or Attands after death	Certification:	4 Homicide determined	28e. Place of Inj building, et	ury · At home, farm, str c. (Specify)	eet, factory, office	Э	28f. Location (S City or Tow	Street and Number or I vn, State)	Rural Route Number,		
	To tha Hospital or At within 24 hours after of To tha Funeral Diract completely filled in by	edical (29a. Certifying Phy (Check only one)	sician: To the best ner: On the basis of and manner sta	of my knowledge, death f examination and/or invated.	occurred at the restigation, in my	time, date and place opinion, death occ	ee, and due to the courred at the time, o	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)		
	To the within To the compl	Me	29b. Signature and title of certifier	,		29c. Licer	nse number		29d. Date signed (Mor	nth, Day, Year)		
	(44)		Moune	Serl-e	m	D56	691		JANUARY 03	ARY 03, 2006		
)_	(7)		30. Name and a ress of person who co	ompleted cause of d	e in (III m 23a) (Type,	Print)				1,0		
			GHOUSIA SULTANA,			IERITAGE	PARK CI	RCLE SIL	VER SPRING	, MD 20906		
	Sta Registr	14	JAN 0 5 2006		ar's Signature	BI						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month MARY HELEN MALLICK 2006 8:20 PM January /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Friends Nursing Home Sandy Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 X F 217-12-5899 82 Yrs. Director June 8 1923 Maryland Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic avant, the Medical Examinari cust be notified at Director Carroll Mt. Airy 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23s or 2530 Penn Hill Road 21771 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itel any injury or other traumatic avent, the Medical Examinations. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No þ Specify: 3X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done di life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Assembler Medical Equipment 10 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Elmer Gingell Helen Mary Bailey 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth V. Mallick, Jr./Son 2530 Penn Hill Road, Mt. Airy, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National 1/18/06 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NOILINUN /Medical Due to (or as a consequence of) **Examiner** ANEMIA WECK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit POST STATUS CASTROINTESTINAL X 83 K Due to (or as a consequence of): Box 68760. SEHILE DemENTIA IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? EhR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown B5782458 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ARTHAITIS 250 No 1 ☐ Yes 2 ☐ No 1 Yes or Attanding Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated within 2 To the 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SPRING rody 1731 BRIGGS MAJC 32. Segistrar's Signature 31. Date filed (Month, Day, Year) State 2006 JAN 06 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year Ronald F. Massarella 9.06 a 2006 13, /Medical January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1∰M 2□F Yrs. 65 201-30-1313 Director 05/03/1940 PA Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ahow th and Mental Hygiene. 27 is marked other than "natural", or itame 23s or 28e-f ahov treumatic event, the Medical Examinal must be notified at 1 Yes 2 □ No Director Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1728 Upper Forde Lane 21074 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∰ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 to No Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Education Elementary/Secondary (0-12) College (1-4or 5+) Steam Fitter Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) t. Peges 1 end 2 should be riment of Heelth and Mental Alphonse Massarella Alice Spina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2 s Department of Heelth ar Important: if item 27 is any injury or other treu Sandra J. Massarella Wife 1728 Upper Forde Lane Hampstead MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 to Burial 2 □ Cremation 3 □ Removal from State Greenmount Cemetery 01/17/2006 Hampstead MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eline Funeral Home Steven M 60773 934 South Main Street Hampstead MD 21074 N 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory **Physician** Acute Days /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (r as a consequence of) ettending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed pulumonia oue to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day 4 Pregnant at time of death signed by the elid be detached for 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? obstructive pulmonary 1 Pres 2 No 3 Probably 4 Unknown been si fibrillatin 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' certificate 2 No 1□ Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐Yes 2√No Certification: To : After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funeral Director:, completely filled in by the f 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies D62180 Fauzi MO Kizvi January 13, 2006 WS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 7thstreet, Frederick, MD 21701 400 West 31. Date filed (Month, Day, Year) 32. Restrar's Signature State **JAN 17** 2006 Registrar

UNK AKG	06-231		Unpen	Please d item#23a	Type or Pringle, 27, 28a-f, per State of M	nt in Bla mE e853 aryland	i ck Indelik 3/8/06 TT Departme	ple Ink. ent of F	. Ensure A dealth and	VII Copie Mental H	s Are ygiene	Legible	. 01121			
			1 - State Registrar				Certifica	ate of	Death		Reg. No	LUUL	01431			
	Physicia /Medic		1. Decedent's Nam	e (First, Middle, L	Antonio	O. Ma	artinez			2. Date of D Month	Da	Day Year y 9, 2006 4c. County of Death Howard year) 9. Birthplace (State or Foreign Country) Mexico 10d. Inside City Limits 12 Yes 2 □ No 0g. Citizen of What Country? Mexico 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Private Maiden Surname) nez Diaz City or Town, State, Zip Code) cr, MD 20785 20c. Location - City or Town, State Beltsville, MD e Funeral Home m MD 20706				
•	Examin		4a. Facility Name (ve street and number)		4b. C	ity, Town, o	or Location of Deat							
16974	Funeral Director		Northbour 5. Social Security N Unk	lumber 6.	mile mark Sex 7.Ag 1⊠M 2□F	er 43 ge (In yrs. last 25		Jessup der 1 Year hs Days	If Under 24 Hrs Hours Min.	8. Date of E	Birth	9 1	Country)			
	and		Usual Residence o 10a. State	10b. County		10c. City, T	own or Location						10d. Inside City Limits			
	BAITIMOFE, MARYIANG Z1Z13-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23s or 28s-f ehow any injury or other traumatic event, the Mudical Example or must be notified at once.	to	Maryland	Prince	George's			L	andover							
	or 28	Directo	10e. Street and Nu	mber			10f.	Zip Code			10g. Ci	tizen of What	Country?			
	ath w	rai	3034	Dodge Pa	rk Road				20785							
	er de	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	,	13. Was De If Yes, s	cedent of H specify Cuba	lispanic Origin? (S an, Mexican, Puer	pecify Yes or ! to Rican, etc.)	No-					
9	Z1Z13~UU30 d within 72 hours aft glene. er then "nature!; or is the Medical Exam.	by F	1 ☑ Never Marr 3 ☐ Widowed	ied 2⊠ Married 4 □ Divorced	1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:	No	1 % Yes	s 2 No	Specify:	xican		Specify:	White			
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3	within 72 sene.	Completed	Elementary/Seco	ondary (0-12)	College (1-4or	5+)	life. DO NO	T use retired	d)	KHIG						
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:	and 2 s and 2 s selth ar n 27 ie		Rocio R.			'										
	s 1 a		20a. Method of Dis	position			of Disposition (i	Name of		Date						
	Saltimore, bernit. Pages 1 ar Department of Hee Important: if item iny injury or other			Cremation 3 (5 ☐ Other (Spec	☐ Removal from State ify)		apeake C		1 .	3/2006	Be]	Ltsvill	e, MD			
	Balti permit. Depertin Importa any inju		21. Signature of	neral Service Lice	ensee	7	22. Name	and Addre	- 1	•						
•	n saesa		174	nav	neur	/	9013	Annar	polis Roa	ad, Lan	ham M	1D 2070	16			
			23a. Part1. Enter t shock, or hea	he disease, of cor	nplications that caused y one cause on each li	d the death. D	o not enter the m	node of dyin	ng, such as cardia	or respiratory	arrest,		Interval Between			
	Physician	4	Immediate Cause disease or condition	(Final	. Multiple								Onset and Death			
	/Medical Examiner		resulting in death)	(W	a consequent										
	Examine:		Sequentially list co	inditions,	b. Due to /or as	a consequenc	no of):									
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	bu, be executed sicien and burial-transit	Examiner	that initiated events resulting in death)	S II	c Due to (or as	a consequenc	ce of):									
ì	BOX 68/6U, eath certificate be ex attending physicien a for use as the burial.	65			d											
6	diffication of physical as the	Medi	IE ECMAN E				-									
	BOX OB/ eath certificate attending phys for use as the	an/l	IF FEMALE: 23b. Was deceden in the past 12		23c. If yes, outcome 1 ☐ Live birth	of pregnancy 2 Fetal dea		pregnancy	,			23d. Date of	•			
	the dear	Physician/Medic	1 ☐ Yes 2 ☐	□No	4 ☐ Pregnant at 9 ☐ Unknown	t time of death	5 Other	(specify)				Month	Day Year			
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	ysician: The is certificete he director, page	Be C	25. Was case refer	red to medical					26. Place of Dea) 'A'	es 2 No			
3	OT VITA Physician: This certifice ral director,	Tof	examiner? 1√∑Yes 2 □	No	Hospital:	ent 2 ER/	Outpatient 3	DOA Oth	er: 4 Nursing H	lome 5 Re	sidence	6 (Stother (S	pecify) at scene			
	ng Ph ng Ph (fer th		27. Manner of Deat 1 □Natural	th 5 Pending	28a. Date of Inju (Month, Da	y Year) 28t	D. Time of Injury	28c. Injun Worl	y at k?	28d. Describe	how inju	ry occurred S	ubject forced			
•	ISIO ttendi death. ctor: A y the fi	cati	2 ☐ Accident 3 ☐ Suicide	investigation 6 ☐ Could not I	1/ // 2000		d 5:20A M		Yes 2 1 No	out of n						
	DIVISION C si or Attending P t after death. I Director: After i d in by the funers	Certification;	4 X Homicide	determined	building, et		, farm, street, fact	ory, office		City or T	own, State	e) MRT_	Rural Route Number, 95 @ mile			
	spital ours serai		29a. Certifier	1□ Certifying P	Interstate hysician: To the best	e expres	SWay	ed at the tin	ne date and place	43 Jessi						
	DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical		XIX Medical Exa	miner: On the basis o and manner st	if examination	and/or investigati	ion, in my o	pinion, death occu	rred at the time	e cause(s	d place, and o	ue to the cause(s)			
	vithir To th	Ň	29b. Signature and	title of certifier			1	29c. License			29d. Da	te signed (Mo	onth, Day, Year)			
) Cau	LOCAD	llaun	id		0	.C.M.E.		Jar	nuary 1	.0, 2006			
CR			30. Name and addr	ess of person who	completed cause of c	death (Item 23)		n Str	eet, Bal	timore,	Mary	yland	21201			
~	Sta Registr		31. Date filed (Mon	th, Day, Year) 1 1 3 2006		rar's Signature										

DHMH 17 Rev 1/2001

Antonio Orozco Martinez

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death January 5, 2006 **Physician** Helen Opal McKinney 10:14 a M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Union Hospital of Cecil County E1kton Cecil If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 8. Date of Birth 9/19/1925 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours West Virginia 1 ☐ M 2 🔯 F 234-36-2329 80 Director Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ?7 is markad other then "natural", or Items 23a or 28e-f show treumatic event. It a Medical Examiner must be notified at Maryland Ceci1 1 ☐ Yes 2 ₹ No North East Direct 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21901 56 Susquehannock Blvd. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, GiveXX 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 □ Yes 2 No Specify ð 3X Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Heelth and Mental Hygiene. em 27 is markad other then College (1-4or 5+) Owner/Operator Florist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Heelth and Mental ! Donald Fields Margaret Oyler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heelth ar Importent: If item 27 ts any Injury or other treu once. Dr. Wayne R. McKinney/son 824 Navaronne Way, Concord California 94518 20b. Place of Disposition (Name of cemetery, crematory or other place) January 11, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State North East, Maryland Forth East Methodist * 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 Khul 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myochdial **Physician** U+0 HV /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner law requires that the death certificate be executed attending physicien and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown 2 NO Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 certificate 1 ☐ Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 30 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred or Attending 1 Alatural 5 Pending Injury within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 □ Yes 2 □ No 2 Accident investigation 3 🗆 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number JANUARY 5 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 DE duite oples 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State JAN 0 9 2006 Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	arylan				ealth a	and M	lental H	ygien Reg. Ñ	UI	96	0 4	33
	Physici	an	1. Decedent's Name (First, Middle, L.	ast)							2. Date of D		ay	Year	3. Time o	f Death
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	Examin	er	4a. Facility Name (If not institution, gi						Location o	of Death		4		nty of Death		
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	th the	Director	10e. Street and Number				10f. Zip	Code	.,			10g. C	itizen d	f What Cou	ntry?	
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36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show to Medical Examiter in ust be invitted at	by Funerai	11. Marital Status 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates:	?	1	Vas Deced f Yes, sped ☐ Yes		spanic Ori n, Mexican Specify:	gin? (Sp , Puerto	ecify Yes or N Rican, etc.)	10-		ace - Americack, White,		
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Man			19a. Informant's Name/Relationship KENNETH E. McFARI)						OCEAN					
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Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Jurieral Service Lice	ensage Average	/				s of Facility	•	OME, SI	ELBY	/ILI	E, DE	. 1997	5
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	Physician		Immediate Cause (Final disease or condition	Metos		Ovan	an i	G-0	Mou	(a					Onset and	Death
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o.	the che	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 □ Live birth 4 □ Pregnant a 9 □ Unknown			Ectopic pr Other (sp						٨	fonth	Day *	Year
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and the same	e mit		30. Name and address of person who	completed cause of codulta	death (Item	23a) (Type, I		Jast	lad Ho	hwe	7 Fem	sete	Tel.	ind P	199	44
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	/Medic	al	Mary Selby Mitche			4h Cib. To	wn, or Location of		suarez 05	County of Dea	0755 *
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Maryland 21215-0036	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Ma	alling Address (S	Street and Numbe	er or Rural Rou	te Number, City	or Town, State,	Zip Code)
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Baltimore,	iges 1 and 2 should be filed it of Health and Mental Hyg If Item 27 is marked othe or other traumatic event,		20a. Method of Disposition 1	Samuel from Charles	cemetery, c	position (Name rematory or other	er place)	Date	20c. t	ocation · City o	r Town, State
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ē	s after	Certification:	4 Homicide	building, etc. (S	pecify)			0	city or Town, Sta	(e)	
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	< m		30. Name and address of person who co	ompleted cause of death	(Item 23a) (Ty	oe, Print)	20 5 SALISI				
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DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	Sta	te of	Marylan	•	artmen <i>tificat</i>				lental Hy	giene Reg. No. (006	014	35
	Physicia		1. Decedent's Name (First, Middl Betty Jane		·y							2. Date of De Month Januar	Day	2006	3. Time of 8:55	Death P M
	/Medic Examin		4a. Facility Name (If not institution	•		oer)				Location o	of Death		4c. C	ounty of Dea		
			718 Merry Go Re 5. Social Security Number	ound Wa		Age (In yrs.	last birthdav)	Mous If Under	it A	Lry If Under	24 Hrs.	8. Date of Bir	h	arro11	thpiace (State of	or Foreian
	Funeral Director		215-20-3080	1 □ M 2		79	Yrs.	Months	Days	Hours	Min.	(Month, Da May 21,	y, Year)	-	thplace (State of ountry) ryland	
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	with th	I Dire	10e. Street and Number 718 Merry Go	Round V	lay			10f. Zip	Code 2177	i			10g. Citize	on of What C	•	
	filed within 72 hours after death with the Maryland Hygiene Hygiene eral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Mar	12. Wa	s Decedined Forc	ent Ever in U.	.S. 13. V	Was Deced f Yes, spec	lent of Hi	spanic Ori n, Mexicar	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	- 14	4. Race - Am Black, Whi	erican Indian, ite, etc.		
	ral', or	þ	3 ₩idowed 4 Divorced	l If Y	es, Give ar or Date			1 🗌 Yes							hite	
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3	should nd Me mark matic	То	John W. 19a. Informant's Name/Relations	Gittir hip (Турө, Рп			19b. Mailir	ng Address	(Street a			A. What Route Number			Zip Code)	
, M	permit. Pages 1 and 2 should be filed within 72 hour poppartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural any injury or othar traumatic avant, the Macilial Expose.		Brenda J. Orri	son - I)augł					Drive		1kersvi				793
5	ages 1 nt of H t: If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (5	3 ☐Remova	al from St	ate	Place of Dispo cemetery, crem	natory or o	ther plac	1					r Town, State	inio
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	2		30. Name and address of person	who complet	ed cause	of death (Iter	m 23a) (Type,	Print)	57	#21	79	MT, A	my.	mn.	2/77/	
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ician dical niner	Leroy Bosley		Sa	les Cleri	k		Hardware	Store
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ician di di di di cal re	1 Surial 2 Cremation 3 C	Removal from State	emetery, crem	natory or other place e Cemeter	. 1	. 1	ŕ	
ician di di di di di di di di di di di di di	21. Signature of Funeral Service Licen:	500	, 22. Mo	Name and Addre	ss of Facility	ns P.A.,	Funeral H	ome ome
niner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of mmediate Cause (Final disease or condition resulting in death)	plications that caused the death one cause pleach line.	Do not ente	er the mode of dying	C ROAD	Damasci c or respiratory a	us, Maryla	Approximate Interval Between Onset and Death
as the buria	Sequentially list conditions, any, leading to immediate ause. Enter Underlying Cause (Disease or injury hat initiated events esulting in death) Last	b. Due to (or as a consequence to or as a consequence to or as a consequence do or as a consequence to or as a con	uance of).					
. ≥ IF	FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 Otho 9 Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of d Month	delivery Day Year
A A	art II. Other significant conditions co	ontributing to death but not resu	alting in the un	nderlying cause give	en in Part I.			to the cause of death? Probably 4 □Unknow
irrector, page 2 should la completed							an 24b. Were prior to death?	autopsy findings availab o completion of cause of ? as 2 \sum No
25 a 25	5. Was case referred to medical examiner?				26. Place of Dea	ath (Check only o		2310
	1 Yes 2 No 7. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injun Worl	4 Nursing F		dence 6 Other (Sp.	necity)
Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		me, farm, stre			28f. Location (S City or Tow	Street and Number or i m, State)	Rural Route Number,
Medical Ce	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	ysician: To the best of my know iner: On the basis of examinat and manner stated.	wledge, death tion and/or invi	occurred at the timestigation, in my of	ne, date and place pinion, death occu	e, and due to the curred at the time, c	cause(s) and manner date and place, and di	as stated. ue to the cause(s)
N 29	9b. Signature and title of ceptrier	1/2 mp		29c. License	o 581		29d. Date signed (Moi	nth, Day, Year)
30.	O. Name and address of person with a	completed cause of death (Item	23a) (Type, F	Print) Ave 5	+ 307	West	orinstor6	ND 2115

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Frank Molnar January 16, A^{M} 2006 9:35 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 13814 Long Ridge Drive Hagerstown Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Director 235-66-7181 63 Yrs Aug. 24, 1942 Ohio Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Bartisfier may a marked other than "naturel", or itema 23a or 28a-1 show ant. If them 27 is marked other than "naturel", or itema 23a or 28a-1 show ury or other traumatic event, the Medical Examination mantitle notifiliad at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Washington 1 ☐ Yes 2X No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13814 Long Ridge Drive 21742 U.S.A. by Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George M. Molnar ပ Mercedes Hazel Mott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole L. Molnar/Wife 13814 Long Ridge Drive, Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of important: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 1/19/2006 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel -1601 Pennsylvania Ave., Hagerstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ARTIOMY disease or condition resulting in death) /Medical Examiner COTONAUL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. | been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 1 Yes 2 No After this certification funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 \$\frac{1}{12}\$ Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide o the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Δn	nended	#	1 - For State Registrar 5 Per Inf	State of Maryl		artment of rtificate of			6. 0	06	01438
231	rended	T	Negistrar J F E I III Decedent's Name (First, Middle, Last)	- · gc / 1 / 0 / c	,6 00	rimodio or	Doam	2. Date of Dea			3. Time of Death
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-	/Medio Examin		4a. Facility Name (If not institution, give s			4b. City, Town,	or Location of D		4c. County		12.03
			Holy Cross Hosp	ital		Silver	Sprin	ıg	Mont	gome	ry
-	Funeral		5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Yea Months Days			h v Year)	9. Birthple	ace (State or Foreign
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	D .		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	anation				110	d. Inside City Limits
	ehow	5	DC None		ashing					10	1 SeYes 2 No
	28a-f	ect	10e. Street and Number			10f. Zip Code			10g. Citizen of \	Milhart Causel	
	with	급	1014 C Street S	. E.		20003			USA	What Count	ry:
	eath eath	Funeral Director		12. Was Decedent Ever	in U.S. 13			? (Specify Yes or No-		e - America	an Indian
	ther d	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No		If Yes, specify Cu	ban, Mexican, P	Puerto Rican, etc.)		ck, White, e	
036	hours after death with the Maryland turel', or iteme 23s or 28s-f ehow al Examinar must be notified at	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	o Specify:		Specify	Bla	ck
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21	within and the state of the sta	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	`life.	DO NOT use retir	red)				
21	ygien ygien t, th	ပ္ပ		2	Car	penter			Unive	·	У
nd	tal H d off	Be	17. Father's Name (First, Middle, Last) Jessie Nicholas					Name (First, Middle,	Maiden Surnan	10)	
∑ Ze	12 should be filed within h and Mental Hygiene. 7 Is marked other then "Iraumatic event, the Hea	2						l Tyree			
Maryland	is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hyglene, item 27 is marked other then "naturel", or items 23a or 28a-1 ehow other traumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship (Ty)					or Rural Route Numbe			20003
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ō	ages nt of t: M it		1 ⊠Burial 2 ☐ Cremation 3 ☐R	emoval from State	ethieh	malory or other pi em Bapt Cemeter	ist ,	11/2006			
Baltimore,	artme orten injury		4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License					reene Fu			, Virgini
89	permit. Pages 1 and 2: Department of Health ar importent: If item 27 is eny injury or other traugues.		Malan E. Shoo	n e h							, VA22314
			23a. Part1. Enter the disease, or compli	cations that caused the							Approximate
	Physician		shock, or heart failure. List only on Immediate Cause (Final								Interval Between Onset and Death
i.e.	/Medical		disease or condition resulting in death)	Sepsis Due to (or as a cor	nsequence of):						
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	n =	ner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury	Due to (or se s nor	requence of):						
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Ö,	e exe cien a urial-	Ä	resulting in death) Last	Due to (or as a cor	· '- ·	_ = .		1.7			
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9	leath certific attending p	/Me	IF FEMALE:	3c. If yes, outcome of pro	non a nov						
Вох	ath or u	ian	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time	Fetal death 3	☐Ectopic pregnan☐ Other (specify)	су			te of deliver onth	y Day Year
o.	y the de	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	ordeam st	_ Other (specify)					
Q.	that ed b deta	된	Part II. Other significant conditions con	tributing to death but not	resulting in the u	inderlying cause g	pven in Part I.	23e. Did to	obacco use cont	ribute to the	e cause of death?
ds	equires en sign tould be	D D	Hypernatremia					1 🗆 Y	res 2 ☐ No	3 🗌 Proba	ibly 4 🔀 Unknown
Ö	2 6 5	lete	Dehydration					24a, Was	an 24b 1	Were auton	sy findings available
Re	The law cate has I	Completed by		·	D			— autop	rmed?	prior to com death?	ipletion of cause of
ta	icien: Th certificate rector, pag		Acute and Chron 25. Was case referred to medical	ic Renal	Fallure	9	26 Place of	1 ☐ Yes Death (Check only o		1 ☐ Yes 2	2 No
<u>></u>	ding Physicien: h. After this certific funeral director,	To B	examiner? 1 ☐ Yes 2 🛣 No	lospital:	2 ER/Outpatie	nt 3 DOA	thor	ng Home 5 ☐ Resid	-	er (Specify	
ō	g Ph ter th		27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time o	of 28c. Inj		28d. Describe h			
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Division of Vital Records,	r Atter de linecte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp.	At home, farm, st	reet, factory, office	9	28f. Location (S City or Tow	Street and Numb vn, State)	er or Rural	Route Number,
	rs ef			1							
	To the Hospitel or Attendit within 24 hours effer death. To the Funerel Director: A completely filled in by the fu	edicai	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	sician: To the best of my ner: On the basis of exar and manner stated.	knowledge, deat mination and/or in	h occurred at the ivestigation, in my	time, date and p opinion, death o	lace, and due to the o occurred at the time, o	cause(s) and ma date and place,	inner as sta and due to	ited. the cause(s)
	o the o the omple	Mec	29b. Signature and title of certifier	grid illariller stated.		29c. Lice	nse number		29d. Date signer	d (Month, E	Day, Year)
	- s + ŏ			4		D479	267		01/02/		
0	18)		30. Name and address of person who co	propleted cause of death	(Item 23a) (Type	D478	007		01/02/	2000	
1-	-6			M.D4701		·	#101,R	Rockville	e, MD 2	20852	
10%	Sta	te	31. Date filed (Month), Day, Year)	2. Registrar's S	ignature		•				
	Registi	ar	JAN 0 5 2006	Marie	H Ann	1.1					

			For State Registrar	State	of Maryland				ealth a Death	and Me	ental H	ygien Reg. N		5	01439
		Sk.	Decedent's Name (First, Middle,	Last)							2. Date of D	eath			3. Time of Death
2	Physicia /Medic		Lillian	в.	O'Ho	ora					Janua:	ry 2	, 2006	ar	11:45 a M
7	Examin	4.3	4a. Facility Name (If not institution,	give street and no	ımber)		4b. City	, Town, or	Location of	f Death		4	c. County of	Death	
4.0			5618 Randolph	Street			-	atts							eorge's
P	Funeral		,	6. Sex 1 ☐ M 2 🕱 F	7. Age (In yrs. In	as <i>t birthday)</i> Yrs.	If Unde Months	r 1 Year Days	If Under 2 Hours		8. Date of B (Month, L Jan • 2	lirth Day, Yea <i>i</i>	9	Coun	lace (State or Foreign try)
N. September 1	Director		215-46-1128 Usual Residence of Decedent		85	115.					Jan. 2	11, 1	(920 N	ort	h Carolina
	and wo		10a. State 10b. County		10c. City	, Town or Lo	cation							1	0d. Inside City Limits
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	the 28a-	Director	10e. Street and Number					p Code				10g. C	itizen of Wha	t Coun	try?
	3a ol		5618 Randolph St	reet			2	0784					USA		
	tiled within 72 hours atter death with the Maryland Hyglene. ther than "natural", or Itema 23a or 28a-f show thit, the Medical Evanination to notified at	by Funeral	11. Marital Status		cedent Ever in U.S		Was Dece	dent of Hi	spanic Orig	gin? (Spec	ify Yes or N	10-	14. Race -		
9	after or ite	Ī	1 Never Married 2 Marrie	Armed F d 1 Tes If Yes, G	2 No				n, Mexican Specify:	, rueito n	iican, etc.)		Black, Specify:		
21215-0036	ours.		3₺ Widowed 4 Divorced	Year or	Dates:			242 140	Зреспу.				эреспу.	*****	
5	72 h	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Deced (Give	dent's Usi kind of w	al Occupa	ation <i>turing</i> most ')	of workin	g	16b.	Kind of Busir	ess/Ind	dustry
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2	led w tygien her ti		17. Father's Name (First, Middle, L	201)			gist	erea			(First Midd	le Maide	n Sumame)	ear	th Care
Suc	be fi	Be	Heber J. Jolly								illia		ii Suiname)		
Ž	d Mer mark matic	2	19a. Informant's Name/Relationsh			19h Mailir	a Addres	s (Straat s					or Town, Sta	te Zin	Code)
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itema 23a or 28a-f show amount injury or other treumatic event, the Maclical Examination at a notified at anone.		Patricia A. O'Ho		hter		•	•					r, MD		
Ġ	1 an Heal tem 2	1	20a. Method of Disposition		20b. P	lace of Dispo	sition (Na	me of	. 17	Da	ite e	20c. l	Location - Cit	y or To	wn, State
ΘĽ	A H I I		1 → Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		n State	emetery, crer Lincol			<i>8)</i>	Janua 200	-	Br	en two o	d	Maryland
Ħ	ortan Injur	- 1	21. Signature of Funeral Service L						s-of-Fedilit			_	me Inc	_	Maryrana
B	Departiment of the particular in the particular		Ville Et	Bour	h	50	0 Un	ivers	ity E	Blvd,	W, S	ilve	r Spri	ng,	MD 20901
	Fire		23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that	caused the death	. Do not ent	er the mo	de of dyin	g, such as	cardiac or	respiratory	arrest,			Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition			G=	4	- D1-		Destan		. 1			Onset and Death
	/Medical		resulting in death)	W	a static o (or as a consequ		er c) PIE	ura,	Prim	ary U	nknov	Wn		2 Years
	Examiner	7A	Conventially liet conditions	h											
	p .≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a consequ	uence of):									
	The law requires that the death certificate be executed the sabeen signed by the attending physician and oase 2 should be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	,										
90,	cian a	û	1000king in doubly Educ	Due to	o (or as a consequ	Jence of):									
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	res that the de igned by the a be detached t	by Physician/Me	Part II. Other significant condition	s contributing to	death but not resu	ulting in the u	nderlying	cause give	en in Part I.		23e. Did	d tobacco	use contribu	ite to th	ne cause of death?
sp.	uires n sign lid be	P	Hypertension								10	Yes :	2⊠No 3	Prob	ably 4 Unknown
CO	w require been si should l	Completed									24a. Wt	as an	24b. We	re auto	psy findings available
Re	The lav	E									pe	topsy formed?	dea	th?	npletion of cause of
tal	, o -	0	25. Was case referred to medical						26. Place	of Death	(Check only	2 (3 x 1)	10	103	
<u>=</u>	Physicien: r this certific ral director,	To B	examiner? 1 Tes 2 XNo	Hospital:	Inpatient 2	ER/Outpatier	nt 3 🗆 🗆	Oth	0.0				6 Other	Specif	y)
0	ding Physicien: h. After this certific funeral director.		27. Manner of Death	1440	e of Injury onth, Day Year)	28b. Time o	f	28c. injun Worl					ury occurred		
jo	Attending r death. ector: After you the fune	atlc	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig	ation			М		Yes 2 ☐ I	No					
Division of Vital Records,	or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	286. Plat	ce of Injury - At ho ding, etc. (Specify	ome, farm, sti	eet, facto	ry, office		2		(Street a		or Rura	l Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the														
	Hospitel 24 hours a Funerel C etely filled i	cal	(Check only 2 Medical E	xaminer: On the	ne best of my kno basis of examina										
	within 2. To the f	Medical	one) 29b. Signature and title of certifier	and ma	inner stated.	1	2	c. License	e number			29d D	ate signed (Month	Dav. Year)
			29b. Signature and title of Certifier	1-14				D250					anuary		
	12		· Creat		upo of door (be-	232\ /T	Ori-+\								
			30. Name and address of person v Don H. Yablolr		1.D. 74	104 Ex	ecut:	lve P	lace,	#502	2, Lar	nham,	MD 2	0706	5
	Sta	ite	31. Date filed (Month, Day, Year)	32	Registrar's Signa	ture	- 00		-						
1	Regist		JAN 06	2006	Registrar's Signa	F FOR	345K								

ledio	an	1. Decedent's Name (First, Middle, I JAMES C. PINE	_ast)		rtificate of		2. Date of Dea	th Day Yeer 4, 2006	3. Time of Death
amin	cal	4a. Facility Name (If not institution, g HERON POINT	tive street and number)		4b. City, Town,	or Location of Dea		4c. County of Death	16:45 P ^N
eral ctor		5. Social Security Number 212–32–0761	Sex 7. Age (i	In yrs. last birthday) 101 Yrs.	Months Day			Year) 9. Birth	place (State or Foreig intry) PA
	tor	Usual Residence of Decedent 10a. State 10b. County MD KENT	1	Oc. City, Town or Lo	ocation HESTERTO	WN			10d. Inside City Limit
	i Director	10e. Street and Number 501 EAST CAMPU	JS STREET		10f. Zip Code 216		1	IOg. Citizen of What Cou USA	intry?
	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 □ Yes 2 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ N		(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White Specify: WHI	, etc.
	ompleted	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	(Give	edent's Usual Occ e kind of work don DO NOT use reti TEACHER	upation e during most of w red)	vorking	16b. Kind of Business/Ir	•
	To Be Co	17. Father's Name (First, Middle, La FRANK WOODWOI					ame (First, Middle, DURAND	Maiden Sumame)	
	-	19a. Informant's Name/Relationship FRANK PINE/SON	(Type, Print)				Rural Route Number PARKTON,	r, City or Town, State, Zi MD 21120	p Code)
- Sama		20a. Method of Disposition 1 Burial 2 X Cremation 3 4 Donation 5 Other (Spe	Themoval nom State	20b. Place of Disponentery, cre CHESAPEA	osition (Name of ematory or other p KE CREMA	TION 01/		20c. Location - City or T STEVENSVILL	
		21. Signature of Funeral Service Lic		F	2. Name and Add ELLOWS	ress of Facility HELFENBE	IN & NEWN	AM FUNERAL	HOME, P.A
ıl		disease or condition resulting in death)	_a	wwo cu	lan C	decida	+ (isch	emic Strale	Interval Between Onset and Death
	ai Examlner		b	tursequence off:	elen (decida	+ (isch	emic Strale	Onset and Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death 8, a M Michael Paul Phillips January 2006 8:23 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Residence: 618 Cecil Avenue Perryville Ceci1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1⊠M 2□F Hours Yrs. 217-20-3882 77 10,1928 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Perryville Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 618 Cecil Avenue 21903 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Year or Dates: 1946-48 White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Aberdeen Proving Ground Elementary/Secondary (0-12) College (1-4or 5+) Civilian Gunner Aberdeen, Maryland Twelve Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Phillips Catherine Roman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 618 Cecil Avenue, Perryville, Maryland Florence C. Phillips (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▼Burial 2 □ Cremation 3 □ Removal from State

4 □ Donation 5 □ Other (Specify) Mt. Erin Cemetery 01/11/06 Havre de Grace, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metaslahe Colou disease or condition resulting in death) Due to (or as a consequence of) 12 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (dr as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of):

Pnysician /Medical

Physician

/Medical

Examiner

Director

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural" ~ " eny injury or other traumatic even."

Examiner Examine The law requires that the death certificate be executed burial-Physician/Medical signed to

by

Completed

2

Certification:

Medical

Box 68760.

P.0.

Division of Vital Records,

Hospitel or Attending Physicien:

death.

after death Director:

within 2 To the

S+IVA

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner 1 ☐ Yes 2 🛣 No

27. Manner of Death

1 XNatural

29a. Certifier

2 Accident

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Day

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

4 ☐ Nursing Home 5 N Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

2**X** No

24a. Was an autopsy performe

1 Yes

26. Place of Death Check onl one

6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

5 Pending

investigation

D 33099

🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

10/06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Promila Suri, M.D., 155 West High Street, Elkton, Maryland 21921

Injury

Registrar

31. Date filed (Month, Day, Year)



			1 - For Stata Registrar	State of N		partment of Health and ertificate of Death		giene Reg. No.2 0 0 6	01442
			1. Decedent's Name (First, Middle, La	ist)			2. Date of Dea		3. Time of Death
5	Physici /Medio	cal	Mur		osephine	Parnell	Januar	-	6 2:40 A ^M
i	Examir	ier	4a. Facility Name (If not institution, giv			4b. City, Town, or Location of Dea	ith	4c. County of Dea	th
_			Frederick Memor: 5. Social Security Number 6.5		tal Ige (In yrs. last birthday	Frederick W) If Under 1 Year If Under 24 Hr.	C Done of Diet	Frederi	
	Funeral Director			1 ☐ M 2 🛣 F	Ven	Months Days Hours Min	n. (Month, Day	(, Year) C	thplace (State or Foreign ountry)
			Usual Residence of Decedent		74 Trs.		April 2	20, 1931 \	/irginia
	rland		10a. State 10b. County		10c. City, Town or L	Location			10d. Inside City Limits
	Man	to	Maryland Frederi	.ck	Frede	rick			No Yes 2 No
	r 288	Director	10e. Street and Number			10f. Zip Code		10g. Citizen of What Co	ountry?
	h witi		200 East 16th	Street		21701		U.S.	Δ.
	deat	Funerai	11. Marital Status	12. Was Deceden	t Ever in U.S. 13.	. Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - Ami	encan Indian,
9	atter or ite	Ē	1 Never Married 2 Married	Armed Forces		If Yes, specify Cuban, Mexican, Pue	rto Hican, etc.)	Black, Whi	e, etc.
ဝ္ပ	ours	d by	3 🔀 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Specify:		Specify: Wi	nite
ည	within 72 hours atter death with the Maryland ane. than 'natural', or items 23s or 28s-1 show 'ts Madical Examinar must be notified at	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give	edent's Usual Occupation re kind of work done during most of wo	orking	16b. Kind of Business	/Industry
2	hen.	п	Elementary/Secondary (0-12)	College (1-4or	(5+) life.	DO NOT use retired)			
7	filed v I Hygia other t		12 17. Father's Name (First, Middle, Last		Boo	kkeeper/Manager		Family Bus	iness
SUE.	o a a a	Be	17. Father's Name (First, Middle, Last)	,			ame (First, Middle, i		
$\frac{2}{8}$	2 should be is and Mental is marked o	မ	John Ashby Lamb				<u>lellie Fr</u>		
Maryland 21215-0036			19a. Informant's Name/Relationship (Type, Print)		ling Address (Street and Number or R			
	t and 2 tealth om 27 i	1	Fay Fitzsimmons = 20a. Method of Disposition	- Sister	20b. Place of Disp	5 Olney Laytonsvi			
Ö	ges it of the if ite		1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State		ematory or other place)	Date	20c. Location - City or	Town, State
	tant:	. ;	4 Denation 5 Other (Specif		_		/9/06	Frederick,	Maryland
Baltimore,	permit. Pages Depertment of the Important: If Its any injury or of	1	21. Signature of Filheral Service Licer	2000) Mc	22. Name and Address of Facility olesworth—William:	s P.A., F	uneral Hom	e
_	Ø□ 3 € Ø		round - 1	Villam	26	6401 Ridge Road,	Damascus	, Maryland	20872
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	line.		ic or respiratory arr	est,	Approximate Interval Between
	Physician	N N	Immediate Cause (Final disease or condition	a	SEP	25/5			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):				11
	LXammer		Sequentially list conditions,	b	- INAMY	TRACT	INFE	27/00	HOUNS
	pe tis	Examine	cause. Enter Underlying Cause (Disease or injury	Dise to (or as	s a consequança of): /				1047
	and tran	кап	that initiated events resulting in death) Last	C. Due to (or a					
8760,	cate be executed physician and the burial-transit			Due to (or as	s a consequence of):				
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	death certificate be executed e attending physician and nd for use as the burial-transit	ician/Me	IF FEMALE:					1	
×	attendattend	lan		220 16 400 0440000					
Box	at the de by the a tached		23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnancy		23d. Date of del	
	c 75	ysic	in the past 12 months? 1 □ Yes 2 ☑ No	1 Live birth	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	ivery Day Year
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			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of rtificate or			giene ()	06	0 443
			1. Decedent's Name (First, Middle, Las	t)				2. Date of De	ath		3. Time of Death
	Physici /Medi		Helery R. Pr	cice				Janua	ry 1 2	Year 2006	12:15A M
	Examir		4a. Facility Nema (If not institution, give Spellman	Specialty	Hospital	4b. City, Town,	or Location of De	ath	4c. Coun	ty of Death	
			and Nursing Cent	er			Chever1v		Pri	nce G	eorge's
	Funeral		5. Social Security Number 6. Se	ox 7. Age ∆M 2□ F	(In yrs. last birthday)	If Under 1 Year Months Day		in. (Month, Da	th (v. Year)	9. Birth	place (State or Foreign ntry)
	Director		579-50-9098 Usuel Residence of Decedent		68 Yrs.			July 9	, 1937	Was	h., DC
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	Mary fed	to	Maryland Prince	George's		Cha	verly				1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number	ocorge B		10f. Zip Code			10g. Citizen o	f What Cou	ntry?
	ath with the Marylan 23a or 28a-f show ust be mailied		2900 Mercy	Lane			2078	5	IIn	ited	States
	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show to Modeal Exc. items and be notified	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of	Hispanic Origin?	(Specify Yes or No erto Rican, etc.)	- 14. Ra	ace - Ameri	can Indian,
9	after or Ite	F	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🛣 N If Yes, Give	0	1 □ Yes 2 🛛 No		erto rilcari, etc./		ack, White,	eic. rican
g	ours,	d by	3 X Widowed 4 □ Divorced	Year or Dates:		2414	о проспу.		Spec	Ame	erican
γ.	nati	Completed	15. Decedent's Ed (Specify only highest gra-		(Give	dent's Usual Occi kind of work don	e during most of v	vorking	16b. Kind of	Business/In	dustry
12	withir sne. than	E G	Elementary/Secondary (0·12) 12th	College (1-4or 5-	+>	DO NOT use retir					
2	be filed within 72 hours after dea ntal Hygiene. nd other than "natural", or Items event. It e Madical Examiliation		17. Father's Name (First, Middle, Last)			Shippi	ng Clerk	lame (First, Middle		Privat	te
au	d be antal ced o	o Be	John P	rice			1071110110101		nie Ga	/	
<u> </u>	2 should be filed v and Mental Hygie 'is marked other t raumatic event, IL	그	19a. Informant's Name/Relationship (7		19b. Mailir	na Address (Stree	et and Number or	Rural Route Numbe			Code)
Ž	nd 2 lith al 27 is r trat		Twanna Price	* * * * * * * * * * * * * * * * * * * *				Wash., I			, 6565,
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Heatth and Men Important: If item 27 is marke any Injury or other traumatic <u>once.</u>	1 3	20a. Method of Disposition		20b. Place of Dispo			Date	20c. Location	- City or To	own, State
Ë	Page ent o nt: tf		1 Burial 2 Cremation 3 1 Other (Specify		Maryland			/6/2006	Tor	ırel,	MD
=	mit. partm yorta / Inju		21. Signature of Funeral Service Licen			. Name and Add		Stewart			
m	Depa Depa Impo any Ir		John T. S.	teron	ITI,	4001	Benning	Rd., N.E		_	
ı			23a. Part1. Enter the disease, or composition of heart failure. List only of	lications that caused one cause on each line	the death. Do not ent e.	er the mode of dy	ring, such as card	iac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Seps	is consequence of):					-	0.000 0.000
	Examiner		Cognosticity list conditions	Infe	cted Decub	iti					
	₽ .≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	,	consequence of):						
	ecute and trans	Examiner	that initiated events resulting in death) Last	C	nditioning						
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Ē	rosuling in death) Last		consequence of): $ilator \ Dep$	ondont I	Poanimat	ower Endla			
200	physi the b	dical		d. Veire	riator Dep	endent i	veshriar	ory railu	re	_	
9 X	eath certific attending p	by Physician/Me	IF FEMALE:	23c. If yes, outcome o	of pregnancy			-			
Rox	atten for u	cian	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death 3	Ectopic pregnan Other (specify)	су			ate of delive onth	ery Day Year
o.	that the de led by the a detached f	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	ine or death 3L	Cities (specify)	-		12		
1	res that igned by be deta	y Ph	Part II. Other significant conditions co	ntributing to death bu	t not resulting in the u	nderlying cause g	iven in Part I.	23e. Did to	obacco use cor	tribute to th	ne cause of death?
Records,	uires sigr		Anoxic	Encephalop	athy			1 🗆 1	/es 2□No	3 🗍 Prob	ably 4 📆 Unknown
Ö	w require been si should I	iete	Diabete	Mellitus	тт			24a. Was	an 24h	Were auto	psy findings available
Ä	The lav	Completed	Diabete	riettteus	<u> </u>			autop	rmed?	prior to cor death?	impletion of cause of
Vital	ician: Th certificate rector, pag	a	25. Was case referred to medical				26 Place of D	1 ☐ Yes eath (Check only o	2 No	1 🗌 Yes	2□ No
>	ysicia s cert direct	O B	examiner?	Hospital: 1 ☐ Inpatier	it 2 ER/Outpatien	t 3 DOA	ther	Home 5 ☐ Resid		har (Specif	41
0	ding Physician: n. After this certific funeral director,	n; T	27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time of			28d. Describe h			/)
ō	tendin death. tor: Aft the fur	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Monat, Day	Year) Injury		Yes 2 No				
Division of	or Atter fter de ilracto n by tr	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, farm, str (Specify)	eet, factory, office		28f. Location (5 City or Tox		ber or Rura	l Route Number,
	urs a urs a sral C										
	To the Hospital or Attending Physician: within 24 hours after deals attended the Funeral Director: After this certification the Funeral Director: After the Funeral director; bompistely filled in by the funeral director;	edical	29a. Certifier 1 XCertifying Phy (Check only one) 2 Medical Exam	rsician: To the best of iner: On the basis of and manner stat	f my knowledge, death examination and/or inv ed.	occurred at the trestigation, in my	time, date and pla opinion, death oc	ce, and due to the c curred at the time,	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)
	To the within To the To the Somp	Me	29b. Signature and title of certifier			29c. Licer	ise number		29d. Date signe	ed (Month, i	Day, Year)
	112		18/18/6	for-	egelektronisch is i start.	12	7577		01/01	106	")
	10		30. Now and address of person who co	ompleted cause of de	ath (Item 23a) (Type,	Print)			1-1		
_	30		Ophnell Cumb	erbatch, l	M.D. 3001	Hospita	1 Drive.	Chever1	y, MD	20785	
	Sta	_	31. Date filed (Month, Day, Year)	32. Registra							
	Registr	ar	JAN 0 6 2006	The second	A STATE OF THE PARTY OF THE PAR						

			1 - For State Registrar		State o	f Maryla		artmen rtificat				lental Hy	giene	006	014	144
	. 實产家		1. Decedent's Name (First,	Middle, Last,)							2. Date of De	ath		3. Time	of Death
	Physic		Frances	Pra	++							Month	Day	Year	1	PM
٧.	/Medi		4a. Facility Name (If not ins			nher)		4h City	Town or	Location	of Dooth	- 1	7.	OS ounty of Death	1030	
	Exami	ier	44						csb		OI DeallI			Leoni	10	
9			5. Social Security Number	6. Se			. last birthday)	If Under	_	If Under	24 Hre	0.0				
	Funeral Director		220-03-2869		M 2160 F	84		Months		Hours	Min.	8. Date of Bir (Month, Da 03/29/	y <i>Year)</i>	9. Birthi Cou	place (State ntry) y Land	e or Foreign
w.			Usual Residence of Deced	ent							1	00/-5/		1141	Jana	
	ylan			County			ity, Town or Lo	cation							10d. Inside	City Limits
	Mar a-f s	ţo	DE	Sussex			Delmar								1 🗀 Ye	s 2 🔼 No
	72 hours after death with the Maryland naturel', or Iteme 23a or 28a-f show dissi Examinar must be rodified at	Funeral Director	10e. Street and Number 387.13 Jame	s Lane				10f. Zip		940				of What Cou	ntry?	
	ne 2	era	11. Marital Status		12. Was Dece	dent Ever in U	J.S. 13.	Was Deced	ent of Hi	spanic Or	igin? (Spe	ecify Yes or No	. 14.	Race - Americ	can Indian	
	ther c	F.	1 Never Married 2	Married	Armed For			If Yes, spec	rfy Cuba	n, Mexica	n, Puerto	Rican, etc.)		Black, White,		
ğ	ol', o	þ	3 ₺ Widowed 4 □ Div		If Yes, Giv Year or Da	e		1 🗌 Yes	2 /2 No	Specify:			Sp	ecity: Wh	ite	
ŏ	2 hou	ed	15. De	cedent's Edu	cation		16a. Dece	dent's Usua	al Decupa	ation			16h Kind	of Business/In		
15	in 72	olet	(Specify only	highest grade	completed)		(Give	kind of wo	rk done d	turing mos	t of worki	ng	Too. King	or pasinessym	dustry	
212	d within 72 ho giene. or than "natu	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	-	lanage					Lau	ındry S	ervic	:e
and	ould be filed we would be filed wented Hygie nrked other falls event, II	To Be C	17. Father's Name (First, M Clarence		sh							(First, Middle, Hurley				
Maryland 21215-0036	2 sho and and is m	F	19a. Informant's Name/Re William Jer									ar, DE		own, State, Zip	Code)	
	1 and Health Sem 27		20a. Method of Disposition				Place of Dispo			7		ate DE		O'h T		
Ö			1 X Buriai 2 ☐ Crem	ation 3 🗆 R	emoval from S	State	cemetery, crei	natory or o	ther place					ion - City or To		
Ξ	Pa Imen tant:		4 □Donation 5 □ Ot	her <i>(Specify)</i>		Biv	valve M	ethod	ist	Cem.	01/0	07/06	Bival	lve, Ma	rylan	.d
Baltimore,	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral S	ervice License	90			. Name an hort				13 E.	Grove	Street	De1m	ar.DF
	9		23a. Part1. Enter the diseashock, or heart failure	muy	cation of that ar	ausod the dee								BULCCU	Approxima	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	ſ	E P	or as a consec	STAG	R	RR	NAL	- 6	DR S R	ASE	25/34jR	Interval Be Onset and	
,09/8	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			or as a consec	·									
O. Box 6	The law requires that the death certifica te has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	311		nth 2 ☐ Feta ant at time of o	al death 3	Ectopic pro					23d.	Date of delive	ory Day	Year
ري ح	res that igned b	by P	Part II. Other significant co	nditions con	tributing to de	ath but not res	sulting in the u	nderlying ca	use give	n in Part I.		23e. Did to	bacco use o	contribute to th	e cause of	death?
Ë	w require been sig should b				····							1 🗆 Y	es 2 🗆 N	o 3 Prob	ably 4]Unknown
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Vital	iician: Th certificate rector, pag	Bec	25. Was case referred to m	edical		-				26 Place	of Death	1 Yes Check onli or	2 No _	1 1 1 103	2000	
	Physician: r this certifica ral director,	0	examiner? 1 ☐ Yes 2 📉 No	Н	ospital:	npatient 2	ER/Outpatien	2 00	Othe	e:						2.
5	Physical Control of the control of t	H ,	27. Manner of Death		28a. Date o		28b. Time of		Bc. Injury	4 🗀 140		ne 5 Resid		Other (Specify) MOSI	MICR
	ding Ph After th funeral	5	Natural 5	ending	(Month	n, Day Year)	Injury	м	Work	?		.ou. Describe II	OW INJURY OF	curred		
DIVISION OF	l or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 0	ould not be letermined	28e. Place buildin	of Injury - At h	ome, farm, stre			es 2 🔲		8f. Location (S City or Tow	treet and Nu	umber or Rura	l Route Nur	mber,
_	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier	rtifying Phys	ician: To the	best of my kno	owledge death	occurred a	at the time	e, date an	d place, a	nd due to the s	ouso/s) and	manner as st	ated.	
	the H in 24 the F plete	Medical	one)	CIOCI EXEINI	and mann	SIS OF BYSHILLS	ation and/or inv	estigation,	in my op	inion, dea	in occurre	ed at the time, o	late and plac	ce, and due to	the cause(s)
	To the To the comple	Σ	29b. Signature and title of o	ertifier				29c	License	number		ż	9d. Date sig	gned (Month, I	Day, Year)	
}	ed		1.50	-cr	-	~		1	205	724	10		1/	5/06		
	B		30. Name and address of p	erson who co	npleted cause	of death (Iter	п 23а) (Туре,		THE RESERVE							
	30			DARIS		266	ARR	OW	200	D	CT.	SALIS	MUR	y 14	0.2	1801
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			Registrar 1. Decedent's Name (First, Middle, La.	o el	Cer	tificate d	Deam	2. Date of Dea	Reg. No.	2 Time of Dooth
Phy	sicia	n			. 1 1 . 0 .			Month	Day Year	214
	edica		Edward 4a. Facility Name (If not institution, giv.		ell,Sr.		n, or Location of Deat	Januar	y 7,2006 4c. County of De	0600 am
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Funo	rol		5, Social Security Number 6. S	rove rd.	rs. last birthday)	Berl If Under 1 Ye	ar If Under 24 Hrs		Worces	
Fune Direc	_		1	12 M 2□F 72		Months Da	ys Hours Min.	(Month, Day	y, Year)	inthplace (State or Foreign Country)
			220-26-3625 Usual Residence of Decedent					LJune	8,1932	Md.
larylan	4		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
Ma 6-1		cto	Md. Wôrce	ster	Berl	.in				1 XYes 2 No
th the		Jire	10e. Street and Number			10f. Zip Cod	0		10g. Citizen of What C	Country?
11 w		Funeral Director	9920 Holly G	rove rd.		218	311		USA	
r dea		Iner	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decedent f Yes, specify (of Hispanic Origin? (Suban, Mexican, Puer	specify Yes or No- to Rican, etc.)		
s afte		by Fu	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give	1	1 ☐ Yes 2√2	No Specify:		Specify: B]	•
If it is in the Maryland filed with the Maryland filed within 72 hours after death with the Maryland Hygiene. Hygiene, Inducel', or items 23a or 28e-f show the remaining the months and the maryland filed.		g p	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						
n 72		Completed	15. Decedent's Education (Specify only highest graduation)	ducation ade completed)	(Give	dent's Usual Oc kind of work do DO NOT use re	ne during most of wo	rking	16b. Kind of Busines	s/Industry
within the		mc	Elementary/Secondary (0-12)	College (1-4or 5+)					Da. 1 +	C
filed Hygir		ပ္ပ	17. Father's Name (First, Middle, Last,)	_ Farm	er	18. Mother's Na	me (First, Middle,	Poultry Maiden Sumame)	Grower
d be antal		00		Purnell			Eliza			5.71a - 1
ie; Ividal y idality (2.1.2.1.2.1.2.2.2.2.2.2.2.2.2.2.2.2.2.2		၉	19a. Informant's Name/Relationship (19b. Mailin	na Address (Str			er, City or Town, State,	Whaley Zio Code)
M 2 s lith ar lith ar 27 is			Edward Lee Pur	, ,		Ť.				
Heal Heal		-	20a. Method of Disposition	11 EII, JI. / SO	DIT 992 D. Place of Dispos	sition (Name o	y Grove	Date Be	rlin, Md. 2 20c. Location - City o	r Town, State
ages intof	5		1 Burial 2 Cremation 3 C	Removal from State	cernetery, cren	natory or other	etery 1/1		Berlin, M	
iit. P artme		-	21. Signature of Funeral Service Licer	//					•	
Definition of permit. Pages 1 and 2 Department of Health a Importent: If item 27 is	ouce		Paracilla	Round D	0	17 t.	Be	ennie Sr	mith Fune	ral Home
			23a. Part 1. Enter the disease, or com	plications that caused the de					alisbury,	Approximate
	14 A		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.			, ,	, , , , , , , , , , , , , , , , , , , ,	,	Interval Between Onset and Death
Physici /Medio	_		disease or condition resulting in death)	a. ASCN		TERIOSC	LEROTIC CA	RDIOVASO	HLAR DE.)	FEW YEARS
Examir	100			Due to (or as a cons	equence on:					
	The	-E	Sequentially list conditions, if any, leading to immediate	b Due to (or as a cons	equence of):					
uted I		Examiner	Cause (Disease or injury							
exection and and all trails		Exa	that initiated events							
icate be executed physician and stransit	5		resulting in death) Last	c. Due to (or as a cons	equence of):					
2 g g	3	g	resulting in death) Last	CDue to (or as a cons	equence of):					
) iii iii iii	:	edicai	resulting in death) Last	cDue to (or as a cons	equence of):					
certific anding p			IF FEMALE:	d23c. If yes, outcome of preg	gnancy				23d. Date of de	blivery
death certific			IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o	gnancy etal death 3	Ectopic pregna			23d. Date of de Month	elivery Day Year
the death certific by the attending p			IF FEMALE: 23b. Was decedent pregnant	d	gnancy etal death 3					
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			1 - For State Registrar	State of	Marylar		artmen rtificate				lental Hy	giene Reg. No.	UU	6	01	446
	Dhysia		1. Decedent's Name (First, Middle,	Last)					-		2. Date of De			V	3. Tir	me of Death
Į.	Physic /Medi		AMANDA	JANE		PARKS					Januar	y 5,	20	06°	7:	:50 P M
7	Examir	ner_	4a. Fecility Name (If not institution,	give street and numb	er)		4b. City,	Town, or	Location	of Death		4c.	County	of Death		
			Alice Byrd Tawe					isfi							mers	
	Funeral		'	i.Sex 7. 1 ☐ M 2 ☆ F		last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th ly, Year)		9. Birthp	place (St	tate or Foreign
	Director		220-66-2946 Usual Residence of Decedent	-A		39 Yrs.					July 4	, 19	16	Virg	inia	1
	land ow		10a. State 10b. County	· · · · · · · · · · · · · · · · · · ·	10c. Ci	ity, Town or Lo	cation							1	Od. Insid	de City Limits
	Mary f sh	ō	 Virginia Acco	mack			TI-O	ngie	r							Yes 2 No
	28a	rec	10e. Street and Number	IIIaCK			10f. Zip		: L			10a. Citi	zen of W	hat Cour	ntry?	
	3a ol	0	4452 Janders La	ne			,		23440)				USA	•	
	ms 2	Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U	J.S. 13.	Vas Deced	ent of Hi	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.))-	14. Race	- Americ	an India	an,
9	after or Ita	Ē	1 ☐ Never Married 2 ☐ Married							i, Puerto	Rican, etc.)		Black	, White,		
8	ral', c	i by	3\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	If Yes, Give Year or Date	es:		1□Yes 2	SK XNo	Specify:				Specify:	Wh.	ite	
Maryland 21215-0036	72 h	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	lent's Usua kind of wor	al Occupa	ation	t of work	ina	16b. Kir	nd of Bus	iness/Ind	dustry	
2	ofthin han han	Id I	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. I	DO NOT us	se retired,)		9					
'n	led w tygie har t	ပိ	4	1			Hom	emak			-			Home	e	
anc	be fi	Be	17. Father's Name (First, Middle, La	ist)							e (First, Middle	Maiden	Sumame)		
2	1 Mer nark	70	Harry Parks						Eliz							
<u>a</u>	12 sh h and 7 is r traur		19a. Informant's Name/Relationship								al Route Numb					
o O	1 and Healt Brm 2 thar		Preston Crockett 20a. Method of Disposition	_(Son)	20h /	4232	Hill sition (Nam	Lane	- Cr		Leld, M	_			_	
چ	to the state of th		1 XBurial 2 ☐ Cremation 3		ate (cemetary, cren	natory or of	ther place	1				cation - C			
altimore,	rtmer rtant riury		' 4 □ Donation 5 □ Other (Spe		As	bury C		-			9, 200	6 Cr	risf:	ield	, Ma	ryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any figury or other traumatic event, I'm Madical Evantment be notified at ance.		21. Signature of Funeral Service Life	Of Crokskaw-	Lant		. Name and Brads				neral 1	Home				
			Mary Deth Bra	dshaw-Pru:	itt		306 W	Ma	in St		Crisfi	.blc	Mary	yland		
			23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	ly one cause on each	h line.	III. DO NOT GINT		e or dying	, such as	1 7						imate I Between and Death
	Physician /Medical		disease or condition resulting in death)	a. Chd	Hag	e Cel	-ghe	me	es.	Ve.	ment	gea.		6	6 -	7/2-3
	Examiner			Due to (or	as a confeed	quence of):									-	
h		ē	Sequentially list conditions,	b. — Due to (or	as a conseq	ruenca of).										
	uted d knsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury													
·	exection and in all tra	Exa	that initiated events resulting in death) Last	c. Due to (or	as a conseq	quence of):								-		
8/60	icate be executed physician and s the burial-transit	dicai		d =												
9	ificat g phy as th	edic		<u> </u>												
ROX	eath certifi attending I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor								2	3d. Date	of delive	rv	
ň	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 🗷 No	1 ☐ Live birth 4 ☐ Pregnan	t at time of d		Ectopic pre Other (spe						Mont		Day	Year
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ώ.	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	ру Р	Part II. Other significant conditions	contributing to deat	but not res	ulting in the ur	derlying ca	use give	n in Part I.		23e. Did to	bacco us	se contrib	ute to th	e cause	of death?
Hecords,	w require been sig should b	ed	Diabelle	Melle	lus	typ	e 11				101	'es 2 🛭	No 3	☐ Proba	ably 4	Unknown
00	law re as be 2 sho	piet	Cosenteal	Hype	rfer	- Just on					24a. Was		24b. We	ere autop	sy findi	ngs available
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10 0	ng Ph ter th		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of I	njury Dav Year)	28b. Time of Injury	28	Bc. Injury Work	at		28d. Describe h				/	
<u> </u>	andir sath. or: Ai	atic	2 ☐ Accident investigat	ion	, ,	,,	M		es 2 🗆 N	10						
UIVISION	or Attanding after death. Diractor: After in by the fune	Certification:	3 Suicide 6 Could not 4 Homicide determine		Injury - At he	ome, farm, stre	et, factory,	office		2	28f. Location (S City or Tow	treet and	Number	or Rural	Route I	Vumber,
	ital o															
	To the Hospital or Attanding Pr within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	edical	Check only 2 Medical Ex	Physician: To the be aminer: On the basis	st of my kno of examina	wledge, death	occurred a	t the time	e, date and	d place, a	and due to the	ause(s) a	and mann	ner as sta	ited.	eo(e)
	within 2 To the complet	Med	5.107	and manner	stated.											
	S T Will	_	29b. Signature and title of certifier	1 /2 1	7	00		License				29d. Date				
	1		Bregores h	. sell	des	mi		120	750	5		01-	07	- 2	200	26
			0. Name an oddress of person wh						-		5) 1 = -					
			GREGORIO M. BE 31. Date filed (Month, Day, Year)	LLOSC, M	ar's Signa	DUZ CHI	NABE	RRY	DR.	SALI	SBURY	MI	2	180) [
	Sta Registr	17.00	JAN 1 0			# A	frank.									

			1 - For State Registrar		aryland / Depa		t of H	ealth a	and M	ental Hyg	•	* ************************************	47
	Physici	an	1. Decedent's Name (First, Middle, L Robert Wilso							2. Date of Dea Month	Day Yee		of Death
	/Media	cal				4h Cihr	Toum or	Location of	of Do oth	JANUARY	2 03,2006	7:56	РМ
4	Examir	ner	4a. Facility Name (If not institution, g						or Death				
	Funeral		CIVISTA MEDICAL 5. Social Security Number 6. 217-72-8720	Sex 7. Ag	e (In yrs. last birthday)	If Under		If Under	24 Hrs.	8. Date of Birth	CHARLE 9. E	irtholace (State	e or D.G ign
	Director			1 X M 2□ F	46 Yrs.	Months	Days	Hours	₩ct	ober.	L'4°,1959	Washir	ngton
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation						10d. Inside	City Limits
	f sho	0	MD Charl	es	Nanjen								es \$ ∕⊡No
	r 28e	by Funeral Director	10e. Street and Number		3	10f. Zip	Code			1	0g. Citizen of What		
	th with	aiD	11870 Woodbur	ry Road		2	066	2		-	USA		
	ams arms	Iner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.				gin? (Spe	cify Yes or No- lican, etc.)		merican Indian,	
36	s afte	Y.	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 🗙 1 If Yes, Give	No	1 🗆 Yes		Specify:		,,	Specify:	white	
215-0036	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28e-f show fra Mayleal Examinar must be notified at	ed b	15. Decedent's	Year or Dates:		dent's Usua		ution			16b. Kind of Busines		:
215	hin 72 in "na Madii	plet	(Specify only highest g	rade completed) College (1-4or 5	(Give	kind of wo DO NOT us	rk done d se retired,	luring mos)		g		a mounty	
CA	rould be filed withlich Mental Hygiene. narked other than natic event, ITE M	Completed	12		Mea	vy E	qui	pmen	t Op	erator	Cons	tructi	.on
nd	ta! Hy d oth	To Be	17. Father's Name (First, Middle, Las	st)				18. Mothe	er's Name	(First, Middle, I	Maiden Sumame)		
Z	should ind Men marke	은	Carroll Posey 19a. Informant's Name/Relationship	(Time Brief)	105 14-18		(0)			McLar		70	
Maryland	d 2 sl th and t7 is r treur		Tiffany Weeks								City or Town, State		
	s 1 and I Health Item 27 other tr		20a. Method of Disposition	, Daugneen	20h Blace of Diane	cition /Alan			- 0	240	00: 1 11 01	- 0	
E	Pages nent of I int: if its iry or o		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Nanjemoy	Bap	tiner place tist	t Cei	m.1/	7/06 N	Nanjemoy	,Maryl	and
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, II a Marical Examinar must be notified at ODGs.	21. Signature of Funeral Service Licensee M00945 22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.											
			23a. Part1. Enter the disease, or co shock, or heart failure. List only	nplications that caused	the death. Do not en	er the mod	e of dying	such as	Zardiac or	respiratory arr	MD. 200	546 Approxim Interval B	ate
	Physician		Immediate Cause (Final disease or condition		hemic	2.	O	4		CO VC		Onset an	d Death
	/Medical Examiner		resulting in death)		a consequence of):		- 601		1-1.	J-E 6- J-			
	Laminer	-	Sequentially list conditions.	b. Due to for as	a consequence of):								
	nsit	min	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 00	a 5011504451165 517.								
á	exection and and rial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):		_					-	
8760,	icate be executed physicien and s the burial-transit	cai		d									
39)	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Med	IF FEMALE:										
Вох	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pr					23d. Date of d Month	elivery Day	Year
P.O.	that the de ed by the a detached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death 5	Other (sp	ecity)					,	
σ.	es that thighed by	y Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying ca	ause give	n in Part I.		23e. Did tob	pacco use contribute	to the cause of	f death?
rds	quires n sign uld be	ed by								1 □ Ye	s 2 No 3	Probably 4	Unknown
ecords,	aw requir s been si 2 should l	plete								24a. Was a		autopsy finding	s available
		Completed								autops perform			cause of
Vital	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?							(Check only on	θ)		
of \	9 0 =	은	1. Ses 2 □ No	Hospital: 1 Inpatie			A Othe	r: 4 □ Nu			nce 6 Other (Sp	ecify)	
no	ding After fune	ion	27. Manner of Death 1 Vatural 5 Pending 2 Accident investigati	28a. Date of Injui (Month, Day	Year) 28b. Time o	M 2	8c. Injury Work	at ? ′es 2.⊟1		8d. Describe ho	w injury occurred		
Division	Attending ar death. actor: After by the fune	fical	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Inju	ury - At home, farm, str			63 2	_	8f. Location (St	reet and Number or i	Rural Route Nu	ımber.
=	el or / s efter il Dire	Certification;	4 Homicide determine	building, etc	c. (Specify)					City or Town	, State)		
	To the Hospitel or Attentwithin 24 hours effer deatl To the Funerel Director: completely filled in by the	Medical (29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and/or in	occurred vestigation,	at the time in my op	e, date and inion, deat	d place, ai th occurre	nd due to the ca d at the time, da	tuse(s) and manner ate and place, and di	as stated. ue to the cause	r(s)
	To the within To the Comp	Ĭ	29b. Signature and title of certifier	n 1	1	29c	License	number		25	9d. Date signed (Moi		
)			yaria	L' Jas	goon	D-	-5088	33			1/3/200	6	
5	2.1		30. Name and address of person who			,							
1	900		Yahia Tagouri, MD 31. Date filed (Month, Day, Year)	, 25500 Po	int Lookout	Road	1.,Le	eonar	dtowr	,MD 206	550		
	Sta Registr		JAN 0 6	2006 32. Registra	un B /	pour							

ROBERT

٢			1 - For State Registrar	State of Maryland		artment of I			giene 006	01448
6	Physici	an	Decedent's Name (First, Middle, Last) OVI	PODNEV				2. Date of Deal Month	Day Year	
1	/Medio Examin	4	4a. Facility Name (If not institution, give s			A	or Location of Dea	ath	4c. County of Dea	ath
	Funeral	S (II	5. Social Security Number 6. Sex 212-09-3424	MEDICAL CA 7. Age (In yrs. Ia M 2 F 89		If Under 1 Year Months Days	APOL (S If Under 24 Hr Hours Min	s. 8. Date of Birth		rthplace (State or Foreign Country) MD
	Director		Usual Residence of Decedent	2. 39	115.			DANOARI	23, 1510	TID
	farylan show	ō	10a. State 10b. County MD KENT	10c. City,	Town or Lo,	CERTOWN				10d. Inside City Limits 12 Yes 2 □ No
	r 28a-f	Director	10e. Street and Number		OHEDI	10f. Zip Code		1	0g. Citizen of What C	Country?
	ath with	raiD	868 WASHINGTON A			2162			USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "naturel; or Items 23e or 28e-f show ship injury or other traumatic event, the Mucleal Exarching man Lie molities at anote.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Öyes 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of I	Hispanic Origin? I an, Mexican, Pue Specify:	(Specify Yes or No- arto Rican, etc.)	14. Race - Am Black, Wh Specify:	
15-0	n 72 h	ietec	15. Decedent's Educ (Specify only highest grade	cation a completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of w	rorking	16b. Kind of Busines	s/Industry
212	giene. er than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		FIGHTER	,		CIVIL SER	VICE
Maryland	ould be fife Mental Hy arked oth atic event	To Be (17. Father's Name (First, Middle, Last) NELSON RODNEY					ame (First, Middle, I	<i>Maiden Sumame)</i> IA SCHWART	Z
	1 and 2 should Health and Men Iom 27 is marke		19a. Informant's Name/Relationship (Type NELSON RODNEY/SO						r, City or Town, State, ${\sf OWN}$, ${\sf MD}$ 21	
Baltimore,	Pages 1 a nent of Hei int: If Item iry or othe	8	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	metery, cren	sition (Name of natory or other pla KE CREMAT			20c. Location - City o	
Balti	permit. Pag Department Important: I eny injury o		21. Signature of Funeral Service License		22	Name and Addre	ss of Facility HELFE	NBEIN & NI		RAL HOME.P.A.
8760,	reate be executed // Medical bhysician and suppressions it is the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or complik shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	ence of):	er the mode of dyi	Post			Approxim te Interval B ween on 1 and Death
.O. Box 68	The law requires that the death certificat ite has been signed by the attending phy tage 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No 9 Unknown	3c. If yes, outcome of pregnar 1 ☐Live birth 2 ☐ Fetal (4 ☐ Pregnant at time of de	death 3□	Ectopic pregnand Other (specify)	у		23d. Date of de Month	alivery Day Year
۵.	w requires that been signed by should be deta	۵	Part II. Other significant conditions con	ntributing to death but not resu	lting in the u	nderlying cause gi	ven in Part I.			to the cause of death? Probably 4 Inknown
Vital Records,		Completed						24a. Was a autops perform	prior to med death?	autopsy fin ings available completion of cause of
	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatient 2	R/Outpatien	at 3 DOA Ot	hor	eath <i>Check</i> only on	ence 6 □Other (Sp.	ecify)
on of	Attending Phir death. ector: After thi by the funeral	tlon: T	27. Manner of C-at 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Inju			ow injury occurred	
Division	of or Attendiated after death in Director: A din by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,		eet, factory, office		28f. Location (St City or Town	treet and Number or F n, State)	Rural Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier Certifying Physics (Check only one)	sician: To the best of my knowner: On the basis of examinati and manner stated.	vledge, death ion and/or in	n occurred at the t vestigation, in my	ime, date and pla opinion, death oc	ce, and due to the courred at the time, d	ause(s) and manner a late and place, and du	as stated. ue to the cause(s)
1-	within 2 to the complet	Me	29b. Signature and title of contilier	So	- ~.	29c. Licen	se number	09	29d. Data signed (Mar	nth, Dey, Year)
-	gates		30. Name and address of person who co	empleted cause of deth (Item	23a) (Type,	Print)	10 to	to	1010	7//71
	Sta		31. Date filed (Month, Day, Year) JAN 1 1 2	32. A witrar's Signati	ure M	Sant 1	17.46 N	1061	11/18	C1620

Amended Item 20b per F.D. 01/17/2006 Carroll County, wj1
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 For State	State of Ma		/ Depa		leaith and	Mental Hy	giene	2006	011.1.9
			Registrer 1. Decedent's Name (First, Middle)	Lacti		Cei	lincale of	Dealli	2. Date of De	Reg. No.	.000	0 1 4 4 J
	Physici	an							Month	Day	Year	3. Time of Death
1	/Medic		4a. Facility Name (If not institution,	elle Reedy			4b. City, Town, o	r Location of Do	01	11	2006 County of Deatl	8:05 P ^M
	Examin	er	Carroll Hosp	-			Westmi		alli		arroll	
	Funeral					st birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Bir	dh.		
	Director		215-58-1347	1 ∰ M 2 □ F 5	55	Yrs.	Months Days	Hours M	in. 05/27/	1950		hplace (State or Foreign untry) yland
	D .		Usual Residence of Decedent								THE .	yrand
	how thow	_	10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
_	Be-f	cto	MD Carrol	1	Han	npstea	d					1 ☐ Yes 2 ∰ No
	2 hours after deeth with the Maryland aturel; or liems 23e or 28e-f ehow ical Examinet must be notified at	Directo	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Co	untry?
	s 23s	ral	4747 Dave Rill				21074			USZ		
	er de Item	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		i. 13. \	Was Decedent of F f Yes, specify Cub	lispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.))- 1	 Race - Amer Black, White 	
8	hours after turel', or Ite	by F	1 ☐ Never Married 2 ∰ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 □ Yes 2 ∰ N If Yes, Give Year or Dates:	NO		1□Yes 2∰ No	Specify:			Specify: Wh:	ite
	72 hours "naturel",		15. Decedent'			16a. Deced	ient's Usual Docup	pation			d of Business/l	
5	within 72 ene. than "nai ne Medic	piet	(Specify only highest Elementary/Secondary (0-12)	t grade completed) College (1-4or 5		(Give life. L	kind of work done DO NOT use retire	during most of w	vorking			
7	d with	Completed	12	College (1°4013	, ,	Cons	truction			Elec	ctrical	
	be filed tal Hygi d other event, II	Bec	17. Father's Name (First, Middle, L	.ast)	-			18. Mother's N	lame (First, Middle	, Maiden S	Sumame)	
<u>a</u>		To	Jack Reedy					Doroth	y B. Ben	edict		
Mar	aum aum		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailin	g Address (Street	a <i>nd Number</i> or	Rural Route Numb	er, City or	Town, State, Z	ip Code)
_	s 1 and if Health Item 27 other tr		Laurie A. Reedy	Wife					m stead 1	MD 21	.074	
o e	of H		20a. Method of Disposition 1 Darial 2 Cremation	3 □Removal from State			sition (Name of natory or other plac		/13/06	20c. Loc	ation - City or 1	Town, State
	nit. Pages 1 and 2 should ertment of Health and Mer ortant: If tem 27 le marke injury or other traumatic.		4 ☐ Donation 5 ☐ Other (Sp		Car	roll C	Cremation	-01 ,	/13/05 	Hamp	stead M	D
saitimore,	permit. Page Depertment Important: If any injury or once.		21. Signature of Funeral Service L	icensee	M0072	- 2	. Name and Addre	Е.	line Fune	ral I	Home	
_	40 = # a		Sleven l	N. Eline					reet Hamp		d MD 21	
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	omplications that caused only one cause on each lin	the death. ne.	Do not ente	er the mode of dyir	ig, such as card	iac or respiratory a	rrest,	12	Approximate Interval Between Onset and Death
F	hysician		Immediate Cause (Final disease or condition resulting in death)	_a Sepsi	S							day 5
	/Medical Examiner		rosaning in doutry	Due to (or as	a conseque	ence of):						
		-	Sequentially list conditions,	b. Hepa	tic	Faile	ine					duys
	nsit	Examiner	Sequentially list conditions, land, loading to mind all to cause. Enter Underlying Cause (Disease or injury that initiated events	-74	1	- £	vena					0- 16
	be executed iclen and burial-transit	xai	that initiated events resulting in death) Last	C. Due to (or as	a conseque	ence of):	vena	eava				ayys
2	ate be executed hysicien and he burial-transit	call		d. ======								
	ding physe as the											
Ž Q	endin endin	N/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregnancy			2:	3d. Date of deliv	very
ם	ne ett	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at 9☐ Unknown			Other (specify)				Month	Day Year
ָר כ	Ine law requires ther the death certifica ste has been signed by the ettending ph bage 2 should be detached for use as th	Physician/Med	9 🗆 Unknown									
ກົ	es m igned	ě	Part II. Other significant condition			-					/	the cause of death?
cords,	pinor pould	Completed	HISTORY OT V	enal cell	CAV	Cinon	na and		- 10	Yes 2L	Mo 3∏Pro	bably 4 DUnknown
ည် .	u 2 C/	npie	pulmonary e	mboli.					24a. Was	osy	24b. Were aut	opsy findings available ompletion of cause of
	page page	ပ်	0							rmed? 2 □ No	death?	
Vital	rnysician: The law this certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?	Unanitely /			Tan		eath Check only	ne)		
5	this c	ဥ	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ■Inpatie		R/Outpatien		4 Nursing	Home 5 ☐ Resi			ify)
NOIS .	e fie	0	1 ☑Natural 5 ☐ Pending		y Year)	28b. Time of Injury	28c. Injur Wor	yat k? Yes 2⊡No	28d. Describe	now injury	occurred	
<u> </u>	death death ctor: / the	icat	2 Accident investigation of Could not be a could no	ot be	ury - At hom	ne farm etre			28f Location (Street and	Number or Pu	ral Route Number,
	after Dire	Certification	4 ☐ Homicide determin	building, etc	c. (Specify)	10, 101111, 3116	set, factory, office		City or To	vn, State)	IVamber of Nat	ai noute Number,
:	spita nours neral		29a. Certifier 1 Certifying	Physician: To the best of	of my know	ledge, death	occurred at the tin	ne, date and pla	ce, and due to the	cause(s) a	ind manner as	stated
:	To the Hospital of Attending within 24 hours after death. To the Funeral Director: Attencempletely filled in by the funeral Director.	Medicai	(Check only 2 Medical E	xeminer: On the basis of and manner sta	examination	on and/or inv	restigation, in my o	pinion, death oc	curred at the time,	date and p	place, and due	to the cause(s)
:	withir To th comp	ĭ	29b. Signature and title of certifier	- 61	1		29c. Licens	e number		29d. Date	signed (Month	. Day, Year)
)	10-		1/2	1 an	hun	2	DY	3453		Sanu	ary 12	2,2006
1	MY		30. Name and address of parson w	no completed cause of	eath (Item 2	23a) (Type, i					0	•
	12		V DIXON Kin		200	MEL	LOTIAL	4 VE	WESTAL	WST	ER in	D 21157
	Sta Registra		31. Date filed (Month, Day, Year)	7 2006 32. Redistra	ar's Signatu	re	R. W.					

			1 - For Stata Registrar	State of Marylar			of Health an <i>of Death</i>	d Mental H	lygiene Reg. No.	06	01450
			Decedent's Name (First, Middle, La.	st)				2. Date of			3. Time of Death
П	Physici /Medi		DAISY J. ROBERTS	SON				Janua Janua	ary 4,	Year 2006	8:20 A.M
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, To	own, or Location of D			unty of Death	1
			Sacred Heart Hor	ne		Hyat	tsville		Pri	nce Ge	eorge's
	Funeral		Social Security Number 6. S			If Under 1 Months 1			Birth	9 Birth	nplace (State or Foreign
	Director		479-20-2294 Usual Residence of Decedent	UM 2LXF 82	Yrs.			Aug.	14, Year) 14, 1923	Io	wa
0	M M		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
No.	i sh	tō	Maryland Prince (George's Hy	attsvi	11e					1 X Yes 2 □ No
4	728a	Director	10e. Street and Number	Jeorge 3)		10f. Zip C	ode		10g. Citizen	of What Cou	intry?
i,	30 O	O E	5805 Queens Chape	1 Road		20	782		U.S.A		
in z 13-0030	porturned of Health and Mental Hygiene. Important if item 27 is marked other than "neturel", or items 23e or 28a-f show eny injury or other treumatic event, the Medical Examinat must be notified at once.	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.1		nt of Hispanic Origin's Cuban, Mexican, P	(Specify Yes or I	No- 14. I	Race - Amer	
9	or ite	Fu	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		nr Yes, specmly 1 ⊟ Yes 2∛3		uerto Rican, etc.)		Black, White	
3	Fet,	d by	3 ☐ Widowed 4 🖔 Divorced	Year or Dates:		T⊟ Yes 20	No Specify:		Spe	ecify: Wh	ite
0000-01717	"net	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deced (Give	dent's Usual (kind of work	Occupation done during most of retired)	working	16b. Kind o	f Business/Ir	ndustry
y i	than	mp	Elementary/Secondary (0-12)	College (1-4or 5+)					-		
א לי	ther int.	ပိ	17. Father's Name (First, Middle, Last)	4	School	ol Tead		Name (Pitters Added		cation	
Ivial ylallu	ntal h	Be	Joseph Shaltanis					Name <i>(First, Midd</i> Le Selbai		iame)	
X	d Me mark matic	^C	19a. Informant's Name/Relationship (1	Type Print)	10h Mailin						
200	th an treu	1	Kathleen (Pat) Sh				ireet and Number or				on, WI 5401
5 5	Heal tem	1 3	20a. Method of Disposition	20b. P	lace of Dispo	sition (Name	of	Date Date		on - City or T	
Dalling G	y or a		1 ☐ Burial 2 🕅 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	emetery, crem ropolita	•		7/2006			
	artme orten injur e.	1	21. Signature of Funeral Servicer Licen	A .			Address of Facility				, Virginia
ם פ	e imp		> Wlonstan	u Base	h 47	739 Bal	Ltimore Av	e., Hyat	tsville		
	nysician /Medical xaminer		23a. Part1. Enter the disease, or companies shock, or heart failure. List only disease or condition resulting in death)	a. Cardiopulmor Due to (or as a consequ	nary Fa	ilure		diac or respiratory	arrest,		Approximate Interval Between Onset and Death
ificate be executed	physician and s the burial-transit	dical Examiner	Sequentially list conditions, and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Uncontrolled Due to (or as a consequence) Due to (or as a consequence)	uanna of):	tensic	n				
The law requires that the death certific		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🗷 No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	Ideath 3□	Ectopic pregi Other (speci				Date of delive	ery Day Year
ires that	signed t	by	Part II. Other significant conditions co Cerebrovascular A				e given in Part I.	- 11			he cause of death?
1900	been s	etec	The state of the s	cerucit, beniz	оригси	<u></u>		- '-	Tes ZIZINO	3 Piot	oably 4 □Unknown
The law requires t	is certificate has l director, page 2 s	Completed						24a. Wa aut per 1 \(\text{Yes}	s an 24l opsy formed? 2 X No	 b. Were auto prior to co death? 1 \(\sum \) Yes 	ppsy findings available mpletion of cause of 2 No
or Attending Physicien:	ertific	Be	25. Was case referred to medical examiner?	11				Death (Check only	one)		
Physicien:	this o	P.	1 163 2 2 10	Hospital: 1 Inpatient 2 I				Home 5 Res			ý)
u	h. After funera	on	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?	28d. Describe	how injury occ	urred	
or Attending	death	cat	2 Accident investigation 3 Suicide 6 Could not be			М	1 Yes 2 No				
or A	after death. Director: After th I in by the funeral	Certification;	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, of	fice		(Street and Nui own, State)	nber or Rura	al Route Number,
the Hospitel	within 24 hours a To the Funerel I completely filled	edical Co	Z Would Late	vsician: To the best of my know iner: On the basis of examinat	wledge, death	occurred at t	he time, date and pla my opinion, death or	ace, and due to the	cause(s) and	manner as si	tated.
the	thin 2 the mple	Med	one) 29b. Signature and title of certifier	and manner stated.			cense number				
Ţ	ž		ANNAN				D51520		29d. Date sign	ry 5,	
			20 Name and address of access of	ampleton and death in	22-) (75		3-3-0		Janua	- 5 5	2000
-			30. Name and address of person who c Bahram Pishdad, N			-	#400 01	into- 35			
	Sta	ė	31. Date filed (Month, Day, Year)	2 Pogiatraria Signat	uria 🙍		, #4U9 UL	LIILON, Má	ryland		
	Registr:		JAN 0 6 2006	Albania Signal	A seed						

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** January 2, Daniel Shirley 2006 4:02 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's Clinton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**XX**M 2□ F 73 Director 229-36-0451 7,1932 Virginia August Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event. It a Madicul Exact in armist to notified at 1 Yes 2XXNo Directo Clinton Maryland | Prince Georges 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5312 Plata Street 20735 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. should be filed within 72 hours after nd Mental Hygiene. 1 X Yes 2 No 1950 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: Yes, Give 3 ₩ Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction Carpenter/Mason 8 f Health and Mental Hygir Item 27 Is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George W. Shirley Elsie May Loveless 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st. Department of Health and Important: If Item 27 Is m any injury or other traum 5312 Plata St., Clinton, Md 20735 Arthur Cook - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery January 11, 2006 Clinton, MD 21. Signature & Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home PA ale 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part Vent the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Oronau /Medical Due to (or as a consequence a) Examiner Myound Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of). Examiner burial-transit 025 Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician COP Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did topacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 400 24a. Was an certificate has autopsy performed 1 Yes 5000 Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 **Y** No Certification: To 1 Nnpatient 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XX atural Injury 5 Pending 1 🗌 Yes investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral C 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 3, 2006 THOHOO Q 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dowison MO 12070 old line centre Steloo walder FMD 31. Date filed (Month, Day, Year) . Registrar's Signature State **JAN 05** 2006 Registrar

			For State Registrar	State	of Marylan		artmen rtificate			ınd M	ental Hy	giene Reg. No.	2008	5 0	1452
	Physici	20	1. Decedent's Name (First, Middle	e, Last)							2. Date of De Month	Day			me of Death
	/Medic	al	Louise Simms					.	t see afficient	1 Daret	Janua:				45 pm ^M
	Examin	er	4a. Facility Name (If not institution Millenium-Sout	-	imber)		4b. City,		Location of Edgew				County of De nne Ar		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Bid (Month, Da	rth	9. 8	irthplace (S	tate or Foreign
	Director		216-44-9651	1 □ M 2 13 F		LO1 Yrs.	Months	Days	Hours ()	Min. O	Sep 2	3, 19		country) ryland	d
pur	*	}	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Insi	ide City Limits
Maryla	f sho	5		Arundel		napoli								1/2	Ýes 2□No
the	r 28e	rec	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of What	Country?	
th with	23a o	ai D	12 Bricin Stre	et #104			214	103				Uni	ted St	ates	
r dea	sems Fr	ner	11. Marital Status	12. Was Dec Armed F	cedent Ever in U. orces? 2 No	S. 13.	Was Deced	lent of Hi	spanic Orig n, Mexican	jin? (Spe , Puerto I	cify Yes or No Rican, etc.)	0-	14. Race - Ar Black, W		an,
.UU36 hours after death with the Maryland	r, or	by Funeral Director	1 Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes If Yes, G Year or I	IV8		1 ☐ Yes	2 00	Specify:				Specify: Black		
5-0036 72 hours aft	ature cul E	ted	15. Deceden	t's Education		16a. Dece	dent's Usua	I Occupa	ation				nd of Busines		
TZTD within 72	iene. r than "naturel", or ilems 23a or 28e-f show It ta Medical Evant ner must be notified at	Completed	(Specify only highes Elementary/Secondary (0-12)) (1-4or 5+)	life.	DO NOT us	e retired	during most)	or workii	ng	Fed	eral 0	Sovern	ment
N B	other th		110	(1)		Kitc.	hen A	id	10 14-45-	d= \$1====	(First, Middle	A fa into a	C.,		
and d be	= 0 \$	Be	17. Father's Name (First, Middle, James Simms	Last)						ence			Sumame)		
Maryland d 2 should be fil	and Menta Is marked aumatic e	우	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address	(Street a			I Route Numb		Town, State	, Zip Code)	
	rt z		Maxine Goode/N	iece		940	Bay F	ores	t Cou	ırt #	326 An	napo.	lis, M	D 2140	03
ore,	of Hea fitem rothe		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation	3 Demoval from	State	lace of Dispo	natory or o	ther plac			ate	20c. Lo	cation - City	or Town, Sta	ate
Pages	ant: H		`4 ☐ Donation 5 ☐ Other (S	pecify)	Br	ewer I	Hill (Ceme	tery	JAN.	6,2006	Ann	apolis	, MD	
Baltimore,	Department of Important: If I any injury or ODC9.		21. Signatur of Funeral Service	tan Ch Annar	apel	. MD									
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the death	n. Do not ent							1_110	Interva	ximate al Between
ħ	ysician	l vi	Immediate Cause (Final disease or condition	C	civilia	0	Ar	ch	111	73771	0				and Death
	Medical aminer		resulting in death)	Due to	(or as a consequ	e 1 G	10				. (9		V		7 7 8017 - 1
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petr	ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	((,									
U, exect	an and rial-tra		that initiated events resulting in death) Last	Due to	(or as a consequ	uence of):									
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x 65	ding pl	Med	IF FEMALE:	220 15 400 0	utcome of pregna	nov									
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. 5	y the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unk		Juli 0_	1 Out 61 (3p	<i></i>							
ecords, P.O law requires that the	signed by the a	by Pi	Part II. Other significant condition	ons contributing to	death but not resi	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did	tobacco u	se contribute	to the caus	e of death?
oquire	been sig should b	edit	Dement	9			- 19				10	Yes 2[⊇No 3□	Probably	4 Unknown
Vital Records, sicien: The law requires t	hasbe e 2 sho	Completed	Hypothy	roidi	m						24a. Was		24b. Were prior t death	autopsy find o completion	dings available n of cause of
a K	his certificate has b I director, page 2 s		Or Man and enforced to modice						00 01	- 4 D 15	1 ☐ Yes	2 No		es 2 No	
	s certi	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital	Inpatient 2	ER/Outpatier	nt 3 DC	Othe		-	<i>(Check only</i> ne 5 ☐ Resi		Other (St	pecify)	-
VISION Of VITA Attending Physicien:	→ Ø	n: To	27. Manner of Death	28a. Date	of Injury nth, Day Year)	28b. Time or		8c. Injury Work		-	8d. Describe			20,7	
SIO	death. ctor: After y the funer	atio	1 ☑Natural 5 ☐ Pendir 2 ☐ Accident investi	gation	,,,,,,	,,	М		Yes 2 □	No _					
Division of or Attending Phys	after de Direct	Certification:	3 Suicide 6 Could 4 Homicide determ	100d 280. Plac	ee of Injury - At ho ding, etc. (Specify	ome, farm, str	eet, factory	, office		2	28f. Location (City or To		d Number or	Rural Route	Number,
To the Hospitel or	within 24 hours after deatl To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the Examiner: On the and ma	ne best of my kno basis of examina nner stated.	wledge, deatl tion and/or in	h occurred vestigation	at the tim	ne, date and pinion, deal	d place, a	and due to the	cause(s) date and	and manner place, and d	as stated. ue to the ca	use(s)
Toth	within To th comp	Me	29b. Signature and title of certifie	r 0	0		290	en en	number	~ *>			signed (Mo		,
			Leyer	C.	ma	ma.	T		065				- 2 -	200	6
			30. Name and address of person 5851 ~ D	who completed car	use of death (Item		Print) G	YA	· IV	.c. Dec	Su	RAN	DA -	2075	-)
	Sta Registi		31. Date filed (Month, Day, Year)	2006	Registrar's Signa	ture	out !								

Amended Items 103 & 19b per F.D. 01/17/2006 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 2-06 :00P M 01-1 Esther L. Shriver /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Min Months 1 □ M 2 🔀 F Yrs Director 188-24-1203 Aug 11 1928 Usual Residence of Decedent 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits r then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Westminster Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3400 Littlestown Pike 21158 USA Completed by Funeral filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) other then Elementary/Secondary (0-12) 4 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be V.J. Schrecengost Nancy Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3300 19a. Informant's Name/Relationship (Type, Print) 2400 Littlestown Pike Westminster, MD 2115 of Disposition (Name of Date 20c. Location - City or Town, State James M. Shriver, Jr/husband 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State importent: i any injury o once. St. John Cemetery 1/16/2006 Westminster, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligenses Pritts Funeral Home and Chapel, P.A. 21157 412 Washington Road Westminster, MD 23a. Part1. Ent. the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Immediate Cause (Final MYOCARDIAL INFARCT101 ACUTE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed ettending physiclen end for use as the burial-translt Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by RENAL ENDSTAGE DISEASE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 20 No 1 Yes After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 □ Yes 2 □ No investigation efter deeth Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide s 24 hours efter a Funerei Dire letely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To tha the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ပ္ 30263 WIL 01-12-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS KHIOD 200 MEMORIAL AVENUE WESTMINSTER, MD 31. Date filed (Month, Day, Year) State Registrar 2006

Earl Edward Schreiner III January 10, 200	
A Facility Name (If not institution, give street and number) 3104 Georgetown Road 4b. Clay, Town, or Location of Death 3104 Georgetown Road 3104 Georgetown Road 3104 Georgetown Ac. County of 3104 Ac. County of 3104 Ac. Cou	
Second Security Number 214-68-0381 Second Security Number 214-68-0381 Second Security Number 214-68-0381 Second Se	
10a. State 10b. County 10c. City, Town or Location 10d. State 10d. County 10d. City, Town or Location 10d. State 10d. City	9. Birthplace (State or Foreign Maryland
South Carroll Crematory 2006 Winfiel	10d. Inside City Limits 1 ¼Yes 2 ☐ No
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South Carroll Crematory 2006 Winfiel	siness/Industry tion Army
South Carroll Crematory 2006 Winfiel	a)
South Carroll Crematory 2006 Winfiel	
23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Averoscleptic Carbon-Scular Disease	City or Town, State
Physician Immediate Cause (Final disease or condition as Arecosuleptic Cartiou-sular Disease	
Examiner	Approximate Interval Between Onset and Death
S- uentially list conditions if any, leading to immediate Due to (or as a consequence of).	
D = 50	e of delivery oth Day Year
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3	ibute to the cause of death? 3 Probably 4 Unknown
autopsy performed? dea	vere autopsy findings available rior to completion of cause of eath?
25. Was case referred to medical examiner? 11	or (Specify) SCENE
27. Manner of Death 28d. Describe how injury occurred light of li	integlass
Solution (Street and Number of Specify) 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	100
29a. Certiflier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (the cause signature)	
	(Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore Marylan	LL. ZUUU
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar	

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** 01-06-2006 8:15a Schaub James Wilbur /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hampstead
If Under 1 Year If Under 24 Hrs. Golden Crest Assisted Living Carroll Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Min. **X**□M 2□F 11-04-1913 Maryland 92 Director 212-03-2353 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State in than "natural", or items 23s or 28e-f ehow the Medical Examinar must be notified at 10b. County 1 ☐ Yes 2 No Baltimore Upperco Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 17728 Falls Road 21155 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 Yes 3 No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Butcher-Grocery College (1-4or 5+) Elementary/Secondary (0-12) Self-Employed 6 Pages 1 and 2 should be filed anneal of Health and Mental Hygic ant: if Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anton В. Schaub Ada May Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2100 Country Fair In. Sykesville, MD 21784 ce of Disposition (Name of Date 20c. Location - City or Town, State John E. Schaub - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Pages Depintment of Important: If it any injury or o 01-10-06 Thurmont, MD Blue Ridge Cem. 4 Donation 5 Other (Specify) 21. Signafule of Funeral Service Licen 22. Name and Address of Facility Eline Funeral Home 934 S. Main St., Hampstead, MD MOO550 MOO550 | 934 S. Main St., Hampst
23a. Part 1. Enter thild disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death AortiL Immediate Cause (Final en05; **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Anemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year be detached for in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Tyes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed? res 2 No 1 Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be funeral director Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 No 3□ DOA Certification: To 1 🗌 Yes After this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Injury or Attending 5 Pending investigation 1. Natural 1 🗌 Yes 2 🗌 No within 24 hours after death. To the Funerel Director: A 2 🗌 Accident the 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1)0051924 Cer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hebert P. Henderson 2677 Manchester Rd Manchester MO 31. Date filed (Month, Day, Year) State JAN 1 0 2006 Registrar

ORIGINAL

Amended Items 25 & 28a - 28f per M.E. 01/11/2006 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Llovd Benjamin Spencer, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Yea Jan. 5, 1 Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 81 Yrs 220-18-3260 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in a Medical Exercities 1: stat the mattles and once. 10a State 10c. City, Town or Location 10d. fnside City Limits 1 **2**√es 2 No Director Maryland Carroll Taneytown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 312 Taney Drive 21787 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No ff Yes, Give Year or Dates: 1 943-81 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2X Married 1 Yes 2 No Specify White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Efementary/Secondary (0-12) College (1-4or 5+) owner/operator restaurant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mildred Moore Lloyd B. Spencer, Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Taneytown, MD 21787 Helen L. Spencer/wife 312 Taney Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State All County Cremation 1/10/2006 Sykesville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign of Fin al Service Lice 22. Name and Address of Facility Hartzler Funeral Home New Windsor, MD 21776 310 Church St. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MASSIGA resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ed by the attending physician and detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Demin Due to for as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CVA 2 No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 sl autopsy performed 1 ☐ Yes Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 1 XYes 27 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After t Certification: 1 Z Natural 5 Pending \mathbf{A}^{M} 1 ☐ Yes 2 X No investigation 01/04/06 8:40 2 Accident Fall. in 24 hour.
the Funeral Direc. 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Angelic Arms 312 Taney Drive, Taneytown, MD 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 2 29c. License number 00 05/924 29b. Signature and title of certified 2 Charles M. Hensgen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) or inner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 Registrar

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au	lid be lental ked o ic eve	To Be	Julian I	Ralph S	Sandy						Mar	y Mar:	ie Mas	ke		
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Division of Vital Records,	or Attendate death Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determi		Place of building	Injury - At h	nome, larm,	street, lactor	y, office		281.	Location (S City or Tow			ural Route Number.
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	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edicai			Examiner: Or	To the be the basi d manne	est of my kn s ol examin r stated.	owledge, de ation and/or	ath occurred investigation	at the tin n, in my o	ne, date and pinion, death	place, and occurred a	due to the o	ause(s) a date and	and manner as place, and due	s stated. e to the cause(s)
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1	357		30. Name and address		who complete	od cause	of death (Ite	m 23a) (Typ 70 O	e, Print) -D VII	1/49e	Rd.	MKCH	ANICSI	ille	, Md 2	0659
* (E. S.)	Sta Registi		31. Date liled (Month	Day, Year)	9 2006	32. R	listrar's Sign	ature	but							s stated. a to the cause(s) th, Day, Year) C 6
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Aleine <u>5,</u> Mary Strunk January 12:05P M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner La Plata

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | October 23,1912 Civista Medical Center Charles 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Maryland 1 □ M 2 💢 F 93 578-20-0360 Yrs. Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Item 27 is marked other than "natural", or Items 23a or 28e-f show other traumstic event, the Medical Examinal matter retified at 1√2 Yes 2 □ No Completed by Funeral Director MD La Plata Charles 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 135 West Quail 20646 Lane USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryiand 21215-0036 1 ☐ Yes 2 TyNo Specify: Specify: white 3√2 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: ff Item 27 te marked other than Elementary/Secondary (0-12) Registered Nurse Nursing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Edward Swann Grace Aleine Swann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Murphy/Daughter 135 West Quail Lane, La Plata, MD 20646 Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Department of H Important: if Ite any injury or ot or other place) Cedar Hill Cemetery 1/10/06 Suitland, Maryland 4 Donation 5 Other (Specify) M0094521. Signature of Funeral Service Licensee ²AREHART° ECHULS FUNERAL HOME, P.A. P.O. BOX 567, LA PLATA, MD Tar Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner meumonia Sequentially list conditions, ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner UNGTERNIZ death certificate be executed Due to (or as a consequence of) burial-P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No ö 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ mass 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

page 2 s has certificate director, Be 2 this Certification: After Hospitel or Attanding death. Director: in by

autopsy performe 1 ☐ Yes 2 No

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 2 No 1 🗌 Yes 27. Manner of Death

28a. Date of Injury (Month, Day Year) 5 Pending investigation

6 ☐ Could not be

determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

3 Suicide 4 Homicide 29a. Certifier

1 Natural

2 Accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

LOGICA

29c. License number D-0057999 29d. Date signed (Month, Day, Year) 06

1 Yes

2□ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Manisha J. Jariwala, MD 11637 Terrace Drive Ste. 103 Waldorf, Maryland 20602 31. Date filed (Month, Day, Year) JAN 0 9

State Registrar

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within 24 hours a To the Funaral I

			1 - For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artme rtifica	nt of Hea te of De	ith and Nath		giene () Reg. No.	06	01460
	Physici	an	1. Decedent's Name (First, Middle, Las. FREDERICK EDW		TEARN	IC.			2. Date of De Month	Day	2 ^{Year} 006	3. Time of Death
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100		A	21140 Beallsvi	lle Road			Dicker	son		Mon	ntgon	nery
92	Funeral Director		569-12-7640	x 7. Age (In yrs. 87	last birthday) Yrs.	If Und Month:		Jnder 24 Hrs. ours Min.	8. Date of Bir (Month, Da May 5	th y, Year) ,1918	9. Birth Cou Cal	place (State or Foreign intry) ifornia
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
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	or 28	Dire	10e. Street and Number			10f. Z	ip Code			10g. Citizen o	of What Cou	intry?
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920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exaction rules for incititional angange.	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	if Yes, sp	ecify Cuban, M	exican, Puerto	Rican, etc.)	В	lack, White	, etc.
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Baltimore,	Fiterr		20a. Method of Disposition 1 Burial 2 Cremation 3	20b. I	Place of Dispo	sition (N	ame of other place)		Date	20c. Location	n - City or T	own, State
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1 5	Physician /Medical		disease or condition resulting in death)	a. Due lo (or as a consec	mence of):	C-6	mi	41				
67	Examiner		Sequentially list conditions	b								
	ted sit	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	uence of):							
oʻ.	execu	Examiner	that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):							
68760,	icate be executed physicien and s the burial-transit	edical	(d								
Вох	The law requires that the deeth certific ate hes been signed by the attending p cage 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown	ıl death 3 ☐	Ectopic Other (s	pregnancy pecify)				Date of delived	ery Day Year
, P.O.	s that the	by Ph	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying	cause given in	Part I.	23e. Did t	obacco use co	ntribute to t	the cause of death?
ord	equire sen sig ould b	ted t							1 🗆 🗅	res 2 🖺 No	3 ☐ Proi	bably 4 Unknown
Division of Vital Records,	The law i	Completed									prior to co death?	opsy findings available ompletion of cause of
Vita	ician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			Othor		h (Check only o	,		
ō	Physer this eral di	n: To	27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of		OA 4 28c. Injury al Work?		me 5 Peside 1			(y)
ion	Attending Physician: or death. ector: After this certifica by the funeral director, p	atlo	1 Dendatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М	Work? 1 ∐ Yes	2 🗆 No				
DIXIS	i i i i i	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, str	eet, facto	ry, office		28f. Location (S City or Tox		mber or Run	al Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knowner: On the basis of examination and manner stated.	owledge, death	n occurre vestigation	d at the time, da n, in my opinior	ate and place, n, death occurr	and due to the red at the time,	cause(s) and r date and place	manner as s e, and due t	stated. o the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			2	c. License nur			29d. Date sign	ned (Month,	Day, Year)
1	D		Meorgi	MD.			D4460	50		1/5/	06	
			30. Name and address of person who could be a compared to		n 23a) (Туре,	Print)	Some	. Mana	lows Pt			20876
*	* Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature	de	Je riel a	CILLAR	UNSFL	ry Ge	VINDOM	NO MI
175	Registr	ar	JAN 0 6 20	JO Marie L	-	1						

1111		•	1 - For State Registrar	State of N	Marylan				lealth a Death	ind Me		jiene	006	0146	
100	Physici		1. Decedent's Name (First, Middle, Las		HR	1 =				2	2. Date of Dea Month	th Day	+ Olo	3. Time of De	ath M
1	/Medic Examin		4a. Facility Name (If not institution, give			<u> </u>	4b. Cit	, Town, or	Location of	f Death	01	4c. C	ounty of Deal		ر
\$ C.	in the second		COASTAL HOSPIG	CE AT 1	HEL	AKE		54	1456	SUR	-4		V -	ONICO	
	Funeral Director		5. Social Security Number 6. Social Security Number 136–10–9516	9x 7./ X IM 2□ F	Nge (In yrs. 95	last birthday) Yrs.	Months	Days	If Under 2 Hours	Min.	3. Date of Birth (Month, Day 1/18/]	, Year)		hplace (State or Fountry) rmany	oreign
	yland yland		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City L	Limits
	Ba-f sl	Director	Maryland Wicomi	co		Salisk	oury							1 ∑ Yes 2[□No
	with the a or 2	Dire	10e. Street and Number 1108 Schumaker D	r.,Apt. 3	306		10f. Z	ip Code 2180	1 4				en of What Co JSA	untry?	
	ma 23	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U		Was Dec	edent of Hi	ispanic Orig	gin? (Spec	ify Yes or No-		4. Race - Ame		
036	al', or Ite	Ď	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Dates	XNo				n, Mexican, Specify:	, Puerto Ri	ican, etc.)	5	Black, Whit Specify:	e, etc. white	
21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "natural", or Itema 23a or 28a-f show event, the Medical Examinal must be notified at	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4o	r 5+)	16a. Dece (Give life.	kind of v	ual Occupa ork done o use retired	durina most	of working	7	16b. Kin	d of Business	Industry	
21	filed wil Hygien sther th		12			WC	rker		40.11.0				tenanc	e	
Maryland	S should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental aumatic event, the Mental aumatic event.	To Be	17. Father's Name (First, Middle, Last) unknown			,				rs Name (nknowi	First, Middle,	Maiden S	Surname)		
Mar			19a. Informant's Name/Relationship (7 Susan A. Horne/d	,, ,		1					Route Numbe Sbury ,			Zip Code)	9
	Heelth tem 27 other tr		20a. Method of Disposition		20b. F	lace of Dispo	osition /N	ame of	1	Dalla			ation - City or	Town, State	
OE I	2 th 9 a		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		(8	isbury	,		1	1/5/0	06	Sal	isbury	, MD	
Baltimore,	permit. Pages 1 and Department of Heelth Important: if Item 27 any injury or other tr QDG:		21. Signature of Funeral Service Limit	See Ois	,		2. Name Hol	and Addres	ss of Facility Fune	ral E		ofes	sional	Associat	tion
8760,	whician and hysician and hysician and hysician and hysician and the burial-transit	dical Examiner	23a Park Enter the disease, or commodise Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or it by that initiated events resulting in death) Last	a. Bue to (or a Due to (or a CHRo.	ATRA as a conseq	uence of):					UIA ZUKA		7	Interval Betwee	
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknowr	2 Feta	I death 3[⊒Ectopic ⊒ Other (pregnancy				2:	3d. Date of del Month	ivery Day Yea	ar
rds, P.	quires that n signed b ıld be deta	by	Part II. Other significant conditions o	ontributing to death	but not res	ulting in the u	undertying	cause give	en in Part I.		23e. Did to			the cause of deat	
al Records,		Completed									24a. Was a autop perfor	sv	24b. Were au prior to death?	utopsy findings ava completion of caus 2 XNo	allable se of
of Vital	Physician: rithis certific ral director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 _ Inpa	tiont 2	ER/Outpatie	nt 3 🗆 [Oth	0.61		Check only or	_	Vi 10	Hara	110
on of	iding Phy th. : After this funeral d		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of li (Month, I		28b. Time of Injury		28c. Injun Worl	4 🗀 [40]	28	ad. Describe h		Other (Spe	city) [123]	CIZ
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not by determined	280. Place of	Injury - At h etc. <i>(Speci</i> i	ome, farm, st (y)	reet, facto	ery, office		28	3f. Location (S City or Tow		Number or Ri	ural Route Number	r.
	ne Hospital	Medical (29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Exam	ysician: To the be niner: On the basis and manner	of examina	owledge, deat ation and/or in	th occurre	d at the tin	ne, date and pinion, deat	d place, ar th occurred	nd due to the o	ause(s) a date and p	and manner as place, and due	stated. to the cause(s)	
	To the within 2 To the complet	ž	29b. Signature and title of certifier					9c. Licens					signed (Mont		
	103	Ý	1.8cm	- /	n	1		2000	-24	10		1/3	5/06		
	100		30. Name and address of person who	ARIS 2	626	m 23a) (Type,	Print)	20w	WOD	CT	SA	21	SBUK	y rus	2180
	Sta Regist		31. Date filed (Month, Day, Year) JAN 1 0 2	2006 32. Regi	strar's Signa	ature	Para M								

			For State Registrar		of Marylai	nd / Depa		t of H	ealth a		lental Hyg		006	0	52
			1. Decedent's Name (First, Middle,	_ast)							2. Date of Dea			3. Time of E	Death
	Physicia		Mary Florence	e Thomp	son				-		Month 01	14	2006	23/8	M
>	/Medic Examin		4a. Facility Name (If not institution, §				4b. City,	Town, or	Location o	of Death			ounty of Deat	h	
		•	Carroll Hospita	al Cente	r		West	mins	ster			Ca	arroll		
	Funeral			Sex	7. Age (In yrs	. last birthday)	If Under	1 Year	If Under 2		8. Date of Birth		9. Birt	hplace (State or	Foreign
	Director		220-09-5967	1□M 2∰F	83	Yrs.	Months	Days	Hours	Min.	06/07/1	922	MI	untry) '	
	P .		Usual Residence of Decedent												
	show	_	10a. State 10b. County			ity, Town or Lo	cation							10d. Inside City 1 ☐ Yes	
	8a-1	cto	MD Baltim	ore	Sp	arks								1 1 105	Z-METINO
	or 2	Die	10e. Street and Number				10f. Zîp	Code			1	0g. Citize	en of What Co	untry?	
	ath v	ra	2107 Stringtown					2115					SA		
	tame	nue	11. Marital Status	Armed F	cedent Ever in U orces?	J.S. 13.	Was Deced If Yes, spec	ent of Hi	spanic Orig n, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14	 Race - Ame Black, White 		
36	s aft	γF	1 ☐ Never Married 2 ☐ Married 3 Widowed 4 ☐ Divorced	l ∏ Yes If Yes, G Year or I	2∰No îve		1□ Yes 2	₽∰ No	Specify:			5	Specify:		
8	hour tural	pa	15. Decedent's		Jaies.	16a Dece	dent's Usua	d Occupa	ation			16h King	WD of Business/	ite Industry	
21215-0036	in 72 "na Padic	Completed by Funeral Director	(Specify only highest	grade completed		(Give	kind of wor DO NOT us	k done d	lurina most	of worki	ng	TOD. KIIK	J 01 Du31116334	moustry	
2	iene.	mo	Elementary/Secondary (0-12)	College	(1-4or 5+)	Hous	sewife					Owr.	Home		
ō	filec Hyg other	BeC	17. Father's Name (First, Middle, La	st)		.1			18. Mothe	r's Name	(First, Middle,	Maiden S	umame)		
<u>a</u>	lenta fenta rked ic ev	To B	John G. Troyer						Sara	ah M	. Curtis	;			
Maryland	shound N		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a		-	il Route Number		Town, State, 2	Zîp Code)	
Σ	alth a 27 is		Russell L. Thomp	son S	on	3458	Gambe	r Ró	. Fir	ikshi	ing MD	2104	8		
J.	of He itam		20a. Method of Disposition			Place of Dispo	sition (Nam	ne of		C			ation - City or	Town, State	
E	Page Bent cont. If Int: If		1 \$\foating Burial 2 □ Cremation 3 `4 □ Donation 5 □ Other (Spe		i State i	lls Rd	,		1	1/18	/2006	But	ler, M)	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" or Itams 23a or 28a-1 show any injury or other traumatic event, the Medical Examing any injury or other traumatic event, the Medical Examing any injury or other traumatic event.	i	21. Signature of Funeral Service Lic	ensee	50					y Eli	ne Fune	cal E	Tome		
m	Ped E and		Steven W	. Elm	Moo	723 93	34 Sou	ıth I	Main :	Stre	et Hamp	stead	MD 21	074	
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that	caused the dea									Approximate Interval Between	een
	Physician		Immediate Cause (Final disease or condition	F	Duwal	a Seca	eda -	to 1	well	Pose	doct Sky	oh a	MOU	Onset and De	eath
A	/Medical		resulting in death)	Due to	(or as a conse	quence of):		/ /	- 1 - ()		-//		,		
h	Examiner		Sequentially list conditions	b											
	p ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		(or as a conse	quence of):									
	ocute ind trans	Examiner	that initiated events	c											
8760,	cate be executed physician and the burial-transit	Ë	resulting in death) Last	Due to	(or as a conse	quence of):									
	icate to physic s the b	dical	,	d											_
9 X	death certific e attending pl id for use as t	Med	IF FEMALE:	025 16 455 5											
Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregr	aldeath 3	Ectopic pre					23	3d. Date of del Month	,	ear
	0 0 0	Physiclan/M	1 ☐ Yes 2 █ No 9 ☐ Unknown	4⊟Preg 9⊟Unk	nant at time of nown	death 51	Other (spe	өспу)							
P.0	law requires that the de as been signed by the a 2 should be detached f		Part II. Other significant condition	s contributing to	death but not re	sulting in the u	ındertvina ca	ause dive	n in Part I.		23e. Did to	pacco us	e contribute to	the cause of de	ath?
ds,	signe signe d be	1 by	(DUGES/IVE	HEART	FAILUR	1	, ,	3			1 🗆 Y	es 2 🗆	No 3□Pr	obably 4 Ur	nknown
Ö	w require been si	etec		// /	7.(1.00,00										
Records,	0 5 0	Completed									24a. Was a autops perfor	v	prior to death?	topsy findings av completion of car	use of
a	ician: The I certificate ha ector, page										1 ☐ Yes	2 No	1 ☐ Yes	2 No	
Vital) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	/	7580		Othe	a/~		(Check only or				-
of	Phys r this ral di	. To	27. Manner of Death			28b. Time o		A	4 LINU		me 5 Reside			city)	
Division	Attending Products of the function of the functions of th	ertification;	1 ENatural 5 ☐ Pending 2 ☐ Accident investiga		of Injury nth, Day Year)	Injury	м	8c. Injury Work	(? Yes 2 □ !	91		17			
İS	Atten dea ctor y the	fica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place	e of Injury - At I	nome, farm, sti	reet, factory	, office					Number or Ru	ıral Route Numb	er,
Ö	al or	erti	4 Homicide	buil	ding, etc. (Spec	ity)					City or Tow	n, State)			
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	alC	29a. Certifier 1 Certifying	Physician: To th	e best of my kr	owledge, deat	h occurred a	at the tim	e, date an	d place, a	and due to the c	ause(s) a	nd manner as	stated.	
	na Ho	edical	(Check only 2 Medical Ex	aminer: On the and ma	basis of examin nner stated.	ation and/or in	vestigation,	in my op	pinion, deat	th occurr	ed at the time, d	ate and p	olace, and due	to the cause(s)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ž	29b. Signature and title of certifier				29c		number				signed (Monti	h, Day, Year)	
)			aleeli	1				D	2080	6		-i/	14/2006		
١	MZL		30. Name and address of person w	no completed car	use of death (Ite	/	-	0		. —	_	1		5 0.	
_	6		PATRICK IV	enis	1000	W 1 P	RTY	ROA	0	El	DONSBUK	Gu	40 21	784	
	Sta		31. Date filed (Month, Day, Year)		Registrar's Sign	nature	_					,		,	
	Registr	ar	JAN 1	7 2006	Mayor	15	Grant	1							

		1	For State Registrar	State of Man		•	nt of Heali te of Dea			ene 006	01463
9	7 39 .		Decedent's Name (First, Middle, Las.	")					2. Date of Death		3. Time of Death
	Physicia		DOROTHY	S.	TV	ILLEY			Month O	Day 200	4 1350 PM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or Loca	tion of Death		4c. County of	Death
		1 b	Peninsula Region	nas medica	1 Cente	2	Salisbu	cry		Wic	mico
6.32	Funeral		5. Social Security Number 6. Se	7. Age (/	n yrs. last birtho	Months		nde 24 Hrs.	8. Date of Birth (Month, Day,	(ear) 9.	Birthplace (State or Foreign Country)
	Director		216-40-4101	_M 2 ∑ F	68 Yr	5.				1937	MARYLAND
	DG 👔	-	Usual Residence of Decedent 10a. State 10b. County	11	Oc. City, Town o	r Location					10d. Inside City Limits
	eho e	ō									1 ☐ Yes 2X☐ No
	28a-1	Director	MARYLAND WICOMIC 10e. Street and Number	U	WILLAF		ip Code		10	. Citizen of Wha	at Country?
	with a sign			DOEC DOAD		1000	•				
	Pa 23	Funeral	36532 THREE BRI	12. Was Decedent Eve	er in U.S.	13. Was Dec	21874 edent of Hispani	ic Origin? (Spe	city Yes or No-	USA 14 Race -	American Indian,
_	iter d	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2X No			edent of Hispani ecify Cuban, Me		Rican, etc.)	Black,	White, etc.
ž	urs a	by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ∐ Yes	2X No Spe	ecify:		Specify:	WHITE
<u>,</u>	within 72 hours after death with the Maryland ene. Than "natural", or itama 23a or 28a-f ehow he Medical Exercitar motal be routhed at	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. D	ecedent's Us	ual Occupation	most of worker	10	6b. Kind of Busin	ness/Industry
7	e e e	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		fe. DO NOT	use retired)		.9		_
7	filed wi Hygien other th	Con		2	F	EGIST	ERED NUF			MEDICA	AL
פ	d ta b	Be	17. Father's Name (First, Middle, Last)				18.1		(First, Middle, M.	aiden Sumame)	
<u>\{ \} \</u>		ပ	CHESTER	SMITH				ESTOL		LaCURTS	
Maryland 21215-0036	2 a 2	ni s	19a. Informant's Name/Relationship (7 KEN TWILLEY/SON	урө, Print)		-	,		/ Route Number,	-	
	ts 1 and 3 thealth item 27 other tr		20a. Method of Disposition		20b. Place of D				AD, WILL		ty or Town, State
altimore,	m O		1 Burial 2 □ Cremation 3 □		cemetery,	crematory of	other place)	l I			
	permit. Pag Department Important: i any injury o		4 ☐ Donation 5 ☐ Other (Specify 21. Sign ture → Ineral Service Licen		FARLOW		EKY and Address of I	1/9/	06	PITTSVI	LLE, MD
Ba	permit. Page Department Important: if any injury o		Karley W	Hast	2	HASTI	NGS FUNE	ERAL HO			DE. 19975
			23a. Part 1 Enter the disease, or comp shock, or heart failure. List only	olications that caused in one cause on each line.	e death. Do no	enter the m	ode of dying, suc	ch as cardiac o	r respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	COP	D						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of	:					Van
7.	LAGITIFICI		Sequentially list conditions,	b							Cars
	pe lisi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence or						
	be executed sician and burial-transit	xan	that initiated events resulting in death) Last	cDue to (or as a c	consequence of	:					
8760	ate be executed hysician and the burial-transit	dical E		i a							
687	tificate og physi as the l	edic		d							
Вох	eath certifii attending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		- 0				23d. Date of	of delivery
m.	death e atte d for	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 4□Pregnant at tir		3 ☐ Ectopic 5 ☐ Other (Month	Day Year
O.	that the de sed by the a detached f	hys	9 🗆 Unknown	9□ Unknown							
κ, π	The law requires that the death certific ate hes been signed by the attending p page 2 should be detached for use as	by P	Part II. Other significant conditions of	ontributing to death but	not resulting in t	he underlying	g cause given in	Part I.	23e. Did tob	acco use contrib	ute to the cause of death?
ğ	w raquire baen si should t	ed							Ye:	s 2□No 3	Probably 4 Unknown
ပ္ပ	law r es be 2 sh	Completed							24a. Was an autopsy	24b. We	re autopsy findings available or to completion of cause of
<u> </u>	The ate h page	Con							perform	egl? dea	ath?]Yes 2□ No
ita	Physician: r this certifica ral director, i	Be (25. Was case referred to medical examiner?					Place of Death	(Check only one)	
\leq	hysik his c	2	1 ☐ Yes 2 2 € N o	Hospital: 1 Inpatient					me 5 Resider		
Ē	ing P	lon	27. Manner of Death 1 ► Natural 5 □ Pending	28a. Date of Injury (Month, Day)	Year) 28b. Tii	ury	28c. Injury at Work?		28d. Describe ho	w injury occurred	
Sic	or Attending after death. Director: After in by the fune	Icat	2 Accident investigation 3 Suicide 6 Could not b	1	(At home for	M stroot foot	1 Tes		29f Location /Str	eet and Number	or Rural Route Number,
Division of Vital Records, P.O.	after after Direct	Certification:	4 Homicide determined	building, etc.	(Specify)	n, stieet, iact	ory, once		City or Town,		or riaras rioute realizer,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2.	edical C	(Check only 2 Medical Exar	ysician: To the best of niner: On the basis of e							
	To the within 2 To the complete	Med	one) 29b. Signature and title of certifier	and manner state	ga.		29c. License nur	mber	29	d. Date signed /	Month, Day, Year)
				Per 11	0		024	1872		1/5/	36
	· (1)		30. Name and address of person who	completed cause of dea	ath (Item 23a) (I	voe Print				1-10	
i	2		PAUL R FLEC	JRY MD	305	TENT	457	Poco.	mokea	ty MO	21851
73	St	ate	31. Date filed (Month, Day, Year)	006 32 Registrar	's Signature	Angel.	,			1	d due to the cause(s) Month, Day, Year) 2(85)
4 1 h	Regist	rar	UNIVUL	13/0	1 10	A STATE OF THE PARTY OF THE PAR	-				

			Obstantial Indiack indendering English A		-	1
			State of Maryland / Department of Health and Maryland / Department of Health / Department of Health / Department	Mental Hygier	29 006	0 464
					No.	
п	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Didney B. It comp, SR.	0/0	6 2006	, 7 8 M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Deat	
		•	Lorien Mt. Airy Mt. Airy	MD	CARRO	LL
	Funeral		5. Social Security Number 6. Sex 6. Sex 7 7 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye.	ar) 9. Birti	hplace (State or Foreign untry)
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	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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Z	9 £ N \$		Pamela J. Porter - Daughter 10612 Brixworth Court			
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Ba	permit. Pag Department Important: I any injury o		Molesworth-Williams	P.A., Fun	eral Hom	e
-			26401 Ridge Road,	Damascus,	Maryland	1 20872
Ш			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	/	1	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition This is a series of the condition of the condi	the ac	Bute	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
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	and trans	Examine	that initiated events resulting in death) last			MO
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8760	ate b hysic the b	licai	a Hypertension			YKS
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Вох	th ce	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of deli	*
	e dea he at hed fo	sici	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
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Vital		ø	25. Was case referred to medical 26 Place of Deat	1 ☐ Yes 2 ☐ ☐ th <i>Check on one</i>	No 1 ☐ Yes	21,360
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of		12	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how in		iiy)
ion	nding F ath. r: After e funera	atio	1 Matural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Pes 2 No			
Division	I or Attendi after death, Director: A I in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street	and Number or Ru	ral Route Number,
ā	el or A safter I Direc d in by	ert	4 Homicide determined building, etc. (Specify)	City or Town, Sta	ite)	
	Hospitel or Attending 44 hours after death. Funerel Director: Afte tely filled in by the fune		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the cause	(s) and manner as	stated.
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	red at the time, date a	nd place, and due	to the cause(s)
	To the within 2 To the Complet	ž	29b. Signature and tile of certifier 29e. License number	29d. [Date signed (Month	. Day, Year)
	,0		Vallen Ceellynso 1) 5474	7 1	7	2006
-	TAKI	1	30. Name and addruss of person, who completed cause of seath (Item 23a) (Type, Print) HILD Levy Min 80, 1011 House Ave.	- 1		0
1	2		HIPN Keilly MD 80, TOll House Ave	Heilel	ICK, M.	1051501
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		,	
	Registr	-	JAN 1 0 2006 Brown & Books			

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death January Day 3, **Physician** 2 0 12:15 рм Dorothy Bridget Tirimacco /Medical 4a. Facility Name (If not institution, give street and number) 39335 Summitt Hill Dr. 4b. City, Town, or Location of Death 4c. County of Death Examiner Mechanics ville St. Marys 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign (Month, Day, Year) 4, 1942 Massuchusetts 5. Social Security Number 6. Sex Birthplace (State or Foreign
 Country) **Funeral** 1 ☐ M 2 ☐ XF 032-30-1270
Usual Residence of Decedent Director 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23s or 28e-1 show the Medical Examiner must be notified at 1 Yes 2 No Be Completed by Funeral Director Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 39335 Summitt Hill Drive 20659 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□ Yes 2 No Specify: White 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. other then " Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Pages 1 and 2 should be filed witness of Health and Mental Hygien tant: If item 27 Is marked other theury or other treumatic event, the Executive Secretary

18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Cosimo Tirimacco Carmella Natale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric Cushenette / Son 689 Winding Stream Way #203, Odenton, MD 21113 20b. Place of Disposition (Name of commetery, crematory or other place)

St. Peter's Church cem. January 7,2006 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Waldorf, MD permit. Page Department of Important: If any Injury or once. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. Rd., Charlotte Hall, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) arian Proysician tew /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause [Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical attending pt d for use as t 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4☐ Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 2 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28d. Describe how injury occurred Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: d in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerel C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of c completed cause of death (Item 23a) (Type, Print) Swite 100 M 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State 2006 Registrar

TOY R. TRICE SR. 06-0044 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrer	State of N	Marylar				ealth and Death	Mental Hy	giene Rog. No	11116	01468)	
	Physici	an	Decedent's Name (First, Middle TOY	e, Last) R .	-	TRICE	SR			2. Date of Da Month	Da		3. Time of Death	_	
	/Medio		4a. Facility Name (If not institution			LICE	4b. City		Location of Dea	JANUAR		2, 2006 County of Dea	1:35P.	М	
	<u> </u>		2719 FAIRDALE T	ERRACE				SILVER SPRING			MC	MONTGOMERY			
	Funeral Director	<u>_</u>	5. Social Security Number 217-13-1973	6. Sex 7. A	Age (In yrs. 29	last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 24 Hrs Hours Min		th y, Year)	9. Birthplace (State or Foreign Country) 1976 Ohio			
			Usual Residence of Decedent								110				
			10a. State 10b. County			ty, Town or Lo					_		10d. Inside City Limit		
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Maryland 21215-0036	and and Is m		19a. Informant's Name/Relations	hip (Type, Print)						ural Route Numbe					
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μor	w = = 4		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		_ 0	emetery, crer	natory or c	other place	s 1/4,	/2006			cia, VA		
Baltimore,	permit. Page Depertment of Important: If any injury of once.		21. Signature of Funeral Sirvice			22	. Name ar	nd Addres	s of Facility	Snowde	n F	uneral	Home P		
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	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line. Approximate Interval Between Interval Between Onset and Death Onset and Death												
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)	13 = 8		· anto	<			-30		C.M.E.			RY 3, 2			
	7	- 20	30. Name and address of person	who completed cause of	death (Item	n 23a) (Type,	Print)	0.	O.H.E.	JJ.	LYNOH	шт Э, 2	.000	-	
			31. Date filed (Month, Day, Year)	B10, MD	trada Ciar	ituro.	111	PENN	STREET	BALTIMOR	E, M	IARYLANI	21201		
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uneral irector		5. Social Security Number 041-24-1079 Usual Residence of Decedent	6. Sex 1 (X) M 2 □ F	7. Age (In yrs. 84	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min,	APRIL A	8. Date of Birth APRIL 20, 1921 9. Birthplace (State of Country) CT				
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3a or 28s	Funeral Director	10e. Street and Number 10f. Zip Code 21620						-	Citizen of What Country?						
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27 is ma		19a. Informant's Name/Relation GEORGE VALUCKA								al Route Numb EAST, MI		n, State, Z	lip Code)		
important: if item 2 any injury or other 20008.		20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 4 ☐ Donation 5 ☐ Other (Place of Dispo cemetery, crei ESAPEA	natory or of	ther place	ion 0		0/2006	20c. Location	-			
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	eral	5. Social Security Number	6. Sex 7. 1 M 2 □ XF	Age (In yrs. last bi	rthday) If Under 1 Year Months Day		n. (Month, D	rth 9. Birthplace (State or Fore Country)				
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	other tr	Verona J. Creek	(Daught	er) 16	641 Gardner	s Ln. She	ephardst	own, WV	25443	t		
ges 1 e	F 05	20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation	3 DRemoval from Sta	20b. Place o cemete	f Disposition (Name of ry, crematory or other pa	lace)	Date January	20c. Location	City or To	wn, State		
SAITIMOTE, permit. Peges 1 er Department of Hea	Injury o	4 □ Donation 5 □ Other (Sp		Smiths	sburg Crema	tory		Smiths	burn.	Maryland		
Daitim Semit. Pe Separtmen mportant:	any Inj DDCe.	21. Signature of Funeral Service L	icensee		22. Name and Add	ress of Facility		Davis Fu				
n 89 F	e 9	Ja Pres dec	Davis	MO1414	12525 Bra	dbury Ave						
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate										
Physic	cian	SHOCK, OF HEART failure. LIST	only one cause on each	ille.						Interval Between Onset and Death		
/Med	ical	Immediate Cause (Final disease or condition	WED	CERCIS		į	WEEK.					
Exam	ner	resulting in death)	a	URO SERS (S								
, D	je li	E										
Certificate be executed rding physicien end	es the buriel-transit	Sequentially list conditions.	Ь	Due to (or as a								
,	Fer X	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of):										
os/ou,	Es Es											
	~	rossking in dodaily 2250										
IS, T.C. BOX es that the death cer igned by the ettendir	seteched for use Physician/	d										
J. DC death he etter	sici	Part II. Other significant condition	na contributing to death	but not resulting in	n the underlying cause g	iven in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death		
requires that the	Phy efect	ALLIE RENAL	. FAILUT	2F.			1□	1 ☐ Yes 2 ☑ No		ably 4 Unknow		
es th	p p		7 1711000	111000			-					
ecords, aw requires t as been signe	pege 2 should					24a. Was	24a. Was an autopsy performed?		24b. Were autopsy findings available prior to			
	2 sh								con	npletion of cause leeth?		
The T	ege Co						10	Yes 2 No	1 [Yes 2□ No		
VICAI Iclan: T Sertificat	Be (25. Was case referred to medical examiner?				26. Place of De	eath (Check only	one)	Ļ			
yslc yslc is ce		1 Yes 2 No	Hospitel:	atient 2 ER/Ou	tpetient 3 DOA	ther: 4 2 Nursing	Home 5□Res	dence 6 Oth	er (Specify)		
ng Phy ter this	nera	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of II	njury 28b. 7	Time of 28c. Injury W			how injury occur				
ath. At	atic	2 ☐ Accident investiga	ation			Yes 2□No						
LIVISION I or Attending P effer death. Director: After	led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	ned 286. Place of	Injury - At home, fa	rm, street, factory, office)	28f. Location (Bf. Location (Street and Number or Rural Route Number, City or Town, State)				
2 e e e	G g	only of Town, Clarey										
hou hou	sly fill	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funersi Director: After this certificate hes	pletely fil	one)	and manner	stated.	wor investigation, in my	gation, in my opinion, death occurred at the time, date a				ing place, and due to the cause(s)		
or ∯ or	E 05	29b. Signature and title of certifier				nse number		29d. Date signed (Month, Day, Year)				
		E JEDOWE	· My		D3	3700		JANUAR	TI Y	7006		
-	1	30. Name and address of person w	no completed cause o	f death (Item 23e) (11			
	2	154 N. ARTIZA	N ST. W	ILLIAMS	PORT, ME	15 C	795					
(9) 36	State	31. Date filed (Month, Day, Year)	27	strar's Signature	- 0							
Re	gistrar	JAN 2 3	2006	euro K	faciles							
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DHMH 16 Rev 6/95

			1 - For State Registrar	State of Ma	ryland /		tment of F <i>ificate of</i>		d Menta		ne ()	06	01469
	* 4		Decedent's Name (First, Middle, Last	")					2. Date	of Death	NO:		3. Time of Death
** F	Physici		Virginia	Elizabeth	T.	liggs			TMor	th uary	8	Year	0933
	/Medio Examin		4a. Facility Name (If not institution, give			IEES	4b. City, Town, o	r Location of De		uarg		ity of Death	0733
			Perinsula Region	al medica	1 Cen	to	Sali	shurd			11/	com	10
F	uneral	Ī	5. Social Security Number 6. Se	x 7. Age	(In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 H		of Birth		9. Birthp	place (State or Foreigntry)
, Di	rector		411-32-1980	JM 2 X (F	78	Yrs.	July 5	110010		28-19			essee
O land	ž		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Loc	ation						Od. Inside City Limit
Maryl	faho	5	100										1 Yes 2 N
32-1980	or 28a-f show onstilled at	Director	MD Somerse 10e. Street and Number	et	Prin	cess	Anne 10f. Zip Code			100	Citizen o	f What Cour	ntry?
V Kill	23a or	0	11974 Edgehill Te	rrace			2185	2			USA		,
	itams 2	Funeral	11. Marital Status	12. Was Decedent Ev	ver in U.S.	13. W	as Decedent of H		(Specify Yes	or No-	14. Ra	ace - Americ	can Indian,
after a	or its		1 ☐ Never Married 2 ☐ Married	Armed Forces?)		N/	an, Mexican, Pu Specify:	епо Hican, е	(C.)		ack, White,	etc.
21215-0036 2 within 72 hours after giene.	널Π	d by	3 AWidowed 4 □ Divorced	If Yes, Give Year or Dates:			Yes 200 No	<i>Зрвспу:</i>			Spec		hite
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ylano ylano ould be		o Be	Unknown							muule, Ma	Odir Suma	ime)	
Aid laryla and Men	mari	2	19a. Informant's Name/Relationship (Tr	vpe. Print)	1	9b. Mailing	Address (Street	Unknov		Number C	ity or Town	n State Zin	Code
. ■ D D E	► \$		Richard Wiggs/Son		100		Pine Bea						
5. j. j. j. j. j. j. j. j. j. j. j. j. j.	Important; if item 27 i any injury or other tre		20a. Method of Disposition		20b. Place	of Disposi	ion (Name of tory or other place		Date			- City or To	
TO TO Page	nt: if ry or		1 Burial 2 □ Cremation 3 □ F			-	Cemetei	' i	/11/200)6 D-	ringo	aa Ama	no Moretti 1
alti niit.	orta / inju	1	21. Sanature of Funeral Service Licens		БССС		Name and Addre)U I.	Tilce	SS AIII	ne, Maryl
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	-55_		23 Part1. Enter the disease, or compl shock, or heart failure. List only o	ications that caused th	he death C	o not enter	the mode of dyir	g, such as card	iac or respira	tory arrest	S Am	ie, MD	Approximate
Prov	sician :		I mediate Cause (Final disease or condition	ino cause on each mile.		12	Ohm U.	. 2					Interval Between Onset and Death
/Me	edical	1	resulting in death)	a Due to (or as a	consequenc	ce of):	Charal scr					-	10 year
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D	=	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	eu leaguar t	to of).	-						1
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760,	sicien a e burial		resulting in death) Last	Due to (or as a	consequenc	ce of):							
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× 6	ettending phy for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcome of	pregnancy						17-57	555.5	
Bo Bath c	etten for u	cian	in the past 12 months?	1 Live birth 2 4 Pregnant at tir	☐ Fetal dea		ctopic pregnancy other (specify)					ate of delive Ionth	ry Day Year
o g	by the tached	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	ine or death	3 🗆 (лпет (<i>specity</i>)						
Division of Vital Records, P.O. Box or attending Physicien: The law requires that the death cerafter death.	8 8	by Ph	Part II. Other significant conditions con	ntributing to death but	not resulting	g in the und	erlying cause giv	en in Part I.	23e	Did tobac	co use cor	ntribute to th	e cause of death?
rds	n sign									1 Yes	2 🗆 No	3 Prob	ably 4 □Unknow
Ö ≥ ×	s been s	Completed							24a	Wasan	24b	Were autor	osy findinos availabl
B 5	ete has page 2	E C							-	autopsy performed	17	death?	osy findings available repletion of cause of
ta	0 .	0	25. Was case referred to medical		-			26. Place of D		Yes 212	No	1 🗆 Yes	2 □ No
F <		To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 🗆 ER/	Outpatient	3 DOA Oth		Home 5		s ∈ □0t	that (Specific	4)
O E	는 중		27. Manner of Death	28a. Date of Injury (Month, Day)		. Time of	28c. Injur			cribe how i			′/
isior kitendin death.	*= =	atlo	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Monar, Day	/ 6a//	Injury		Yes 2 □No					
Vision Properties	recto	tife:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, (Specify)	farm, stree	t, factory, office		28f. Loca	tion (Stree or Town, S	t and Num	ber or Rura	l Route Number,
Di itel on	iei Di	Certification:									,		
Division of Vital Records, P.O. Box 68 e Hospitel or Attending Physicien: The law requires that the death certifical 24 hours after death.	To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of ner: On the basis of ea and manner state	Kallimation	lge, death o and/or⊣nve	ccurred at the tin stigation, in my o	ne, date and pla pinion, death oc	ce, and due to	o the caus time, date	e(s) and m and place	nanner as sta , and due to	ated. the cause(s)
the hin 2	To th	Me	29b. Signature and title of certifier				29c. Licens	number		29d.	Date sign	ed (Month, L	Day, Year)
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S _{rip} of the state of the stat							1/0 >	1 3) 7		Ja	V 3	2 4 (-0
T Y			30. Name and address of person who co	impleted cause of dea	th (Item 23a	a) (Type, Pr	int)	10					
O L			30. Name and address of person who co					ST, SAL	ISBUR	y M)	2150	14	

			1 - State o	f Maryland / D		rtment of H				iene)6	0 4	70
п	Physici	an	Decedent's Name (First, Middle, Last)						2. Date of Deat Month	Day	Yeer	3. Time o	of Death
	/Medic		Mamie R. Wille						January	4 :	2006	1325	Рм
	Examin	er	4a. Fecility Name (If not institution, give street and nut	nber)		4b. City, Town, o		of Death		4c. Count		ı	
	Funeral		SunBridge Care Center 5. Social Security Number 6. Sex	7. Age (In yrs. last birth	ndav)	Elktor If Under 1 Year		24 Hrs.	8. Date of Birth	Cec		place /State	or Foreign
	Director		221-50-3064 1□M 2X)F		rs.	Months Days	Hours	Min.	(Month, Day, May, 14,	Yeer)	Per	place (State intry) nsy1va	nia
	pu ,		Usual Residence of Decedent										
	shov	5	10a. State 10b. County	10c. City, Town								10d. Inside C	ity Limits
	the M	Director	Delaware New Castle 10e. Street and Number	Claym	lon	10f. Zip Code				0- 011			- XIII
	with Sa or		2610 Garfield Avenue			19703	2		"	og. Citizen of Unite		•	
	death ms 23	Funeral	11. Marital Status 12. Was Dece	edent Ever in U.S.	13. V	Vas Decedent of H Yes, specify Cubi	_	gin? (Spe	cify Yes or No-			ican Indian.	
9	or Iter	표	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes	2 1 No				n, Puerto I	Rican, etc.)	Bla	ck, White		
8	ours rai', c	d by	3 X Widowed 4 □ Divorced If Yes, Giv Year or D	θ		☐ Yes 2∏ No	Specify:			Specia	y: Wh:	ite	
7	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28a-f show the Medical Evarrings must be nutified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	ent's Usual Occup kind of work done	durina mos	t of workir	ng	16b. Kind of B	usiness/li	ndustry	
12	withir ene. than	щ	Elementary/Secondary (0-12) College (1	-4or 5+)		OO NOT use retired	a)			T- 11.	O-	II	
9	filed Hygid Sther ent, t		17. Father's Name (First, Middle, Last)	<u> </u>	поі	nemaker	18. Mothe	er's Name	(First, Middle, M			n Home	?
Maryland 21215-0036	2 should be a and Mental is marked o	To Be	Elmer Krieger				Mar	tha	Laudig				
ary	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Type, Print)	19b. l	Mailin	g Address (Street				City or Town	State, Zi	p Code)	
Σ	1 and 2 Health tam 27 i		Adele W. Taylor/Daught			Garfield	Avenu	ıe, C	laymont	, Delav	vare	19703	
Baltimore,	Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. Int: If Itam 27 is marked other than "natural", or Items 23a or 28a-1 show int: If Itam 27 is marked other than "natural", or Items 23a or 28a-1 show int or other traumatic event, the Mudical Exercities ringst be nutified at		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from	20b. Place of E	Dispo:	sition (Name of natory or other plac 1 Memoria	ea) J	Janua	ry 9,	20c. Location	City or T	own, State	
ţ	t. Partmen tant:		* 4 □ Donation 5 □ Other (Specify)	Park			12	2006		New Cas			
Bal	permit. Pages Department of I Important: If Its any injury or o		21. Signature of Funeral Service Licensee	men	Hi 10	Name and Addre Cks Home 3 W. Sto	for ckton	Funer Stre	cals, P. eet, Elk	A. ton, M	aryla	and 21	921
			23a. Part 1 Enter the disease, or complications that c shock, or heart failure. List only one cause on e	aused the death. Do no ach line.	ot ente	er the mode of dyin	ng, such as	cardiac o	r respiratory arre	est,		Approximation interval Bet Onset and	tween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aganic b	100	in sy	ndro	me				ankon	wn.
	Examiner		Due to	oth a consequence of	<u>f):</u>	-						Zubn	101.5
		er	Sequentially list conditions, Tany leading to intra-clast cause. Enter Underlying Cause (Disease or injury	or as a consequence of	n.	208)						-111/201	1102
	cuted nd ransit	Examiner	that initiated events										
Ö,	ate be executed oby sician and the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of	f):								
8760,	cate be ex physician the buria	dical	d										
9	death certificate be executed the attending physician and ad for use as the burial-transit	/Me	IF FEMALE: 23c If yes out	come of pregnancy								-	
Вох	atten atten I for u	Physician/Me	in the past 12 menths?	irth 2 Fetal death ant at time of death		Ectopic pregnancy Other (specify)	,			1	te of deliv onth		Year
P.O.	y th	hysi	1 Yes 2 No 9 Unknown 9 Unknown										
	th ed de	by P	Part II. Other significant conditions contributing to de	eath but not resulting in t	the un	derlying cause giv	en in Part I.		23e. Did tob	acco use con	tribute to t	he cause of o	death?
ıd	law requires as been sign 2 should be	edt	Dianeles Mel	ilus					1 □ Ye	s 2 🗆 No	3 🗌 Proi	oably 4 🔟	nknown
Records,	has be	ompleted							24a. Was ar		Were auto	opsy findings impletion of c	available
<u>=</u>	Th ate pag	Con							perform	red %	death? 1 🔲 Yes		2000 01
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?			04	1		(Check only one				
o	dii d	. To	1 Yes 2 No 1 I I	npatient 2 ER/Outp			4 E Mu		ne 5 Reside			(y)	
on	ding Ph h. After th funeral	tion	1 Natural 5 Pending (Mont		ury	28c. Injun Worl M 1	yai k? Yes 2.⊟1		8d. Describe ho	w injury occur	red		
Division	il or Attanding atter death. I Director: Afte d in by the fune	ertification;	2 Suicide 6 Could not be	of Injury - At home, farning, etc. (Specify)	n, stre				8f. Location (Str	eet and Numb	er or Run	al Route Num	ber,
Ö	s afte	Cert	4 Homiciae buildii	ng, etc. (Specify)					City or Town	, State)			
	To tha Hospital or At within 24 hours atter d To tha Funaral Direct completely filled in by	edical (29a. Certifier (Check only one) Certifying Physicien: To the band manual manua	asis of examination and/	death or inv	occurred at the tin estigation, in my o	ne, date and pinion, deat	d place, a th occurre	nd due to the ca d at the time, da	use(s) and ma ite and place,	anner as s and due t	tated. the cause(s	:)
	To tha l	5	29b. Signature and title of certifier	C 110	\	29c. Licens	e number		29	d. Date signe	d (Month,	Day, Year)	
)			> Seretick	evo mi)	200	0233	521		1/4/0	06.		
			30. Name and address of person who completed causes and the order of the second of the	e of death (Item 23a) (T	ype, S	Frint) F Suite 3	33, 8	Ee_k	Ten 0	no 219	21		
•	Sta Registr	ile	31. Date filed (Month, Day, Year) JAN 0 9 2006	egistrar's Signature	,								

Please Type of Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yeer **Physician** Phyllis Gugeler Weyl 2006 4, /Medical January 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Pleasant View Nursing Home Mt. Airy Carrol1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ☐ M 2 🙀 F 92 Director 485-48-8274 Jan. 29, 1913 Iowa Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location rel', or Iteme 23a or 28e-f ehow Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Director Arkansas Washington Favetteville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 17411 Robinson Road permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Menial Hygiene. Important: If item 27 is marked other then "natural", or Iteme 23a enty injury or other traumatic event, the Medical Examinat must page. USA 72704 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred Wagner ၉ Maggie Gugeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28711 Clarksburg Road, Mina M. Luther - Daughter Damascus, Maryland 20872 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Jagger Cemetery 1/12/06 Danville, Iowa 21. Signature of Fun ral Service Lipensee 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 1. For the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 1. For the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 1. For the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ALZHEIMER'S Immediate Cause (Final disease or condition resulting in death) DEMENTIA **Physician** NONTUS /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. physicien use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Year 4☐Pregnant at time of death 5 Other (specify) P.O. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by cate has been sig , page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Aursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certified 29c License number 29d. Date signed (Month, Day, Year) D26499 -6-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald Miller, M.D. 4 Culwell Drive, Mt. Airy, MD 21771 , 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 0 2006 Registrar

			1 - For State Registrar	State of M	aryland / D	epartme Certifica			nd Mental	Hygier	Z U U b	01472
	Dhuoisi		1. Decedent's Name (First, Middle,	Last)					2. Date Mont	of Death) N	3. Time of Death
	Physici /Medic		RALPH SUTHERLA	AND WOODRUF	F				_	uary 1	Day Year L. 2006	3:05 a M
	Examir	er	4a. Facility Name (If not institution,			4b. Cit	, Town, or	Location of	Death		4c. County of Dea	
300		1. 18	Doctor's Commi				inham er 1 Year	If Under 24	411		Prince (
	Funeral Director		508-09-2820	1 M 2 □ F	ge (In yrs. last birth	Months		Hours	Min. (Mont	h, Day, Yea	11)	thplace (State or Foreign ountry)
			Usual Residence of Decedent		89 '				June	27,	1916 Ne	braska
	rylan how		10a. State 10b. County		10c. City, Town	or Location						10d. tnside City Limits
	Ba-1-e	cto	Maryland Prince	George's	Lanham							1 ☐ Yes 2 X No
	vith th	Dire	10e. Street and Number			10f. Z	ip Code			10g. (Citizen of What C	ountry?
	s 23s	ral	7308 Lois Lane				0706				S.A.	
	Item Instru	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☒ Marrie	12. Was Decedent Armed Forces d 1 ☐ Yes 2 ☑	?	If Yes, sp	edent of His ecify Cubai	spanic Origi n, Mexican,	in? (Specify Yes Puerto Rican, etc	or No- c.)	14. Race - Am Black, Whi	
21215-0036	within 72 hours atter death with the Maryland ene. than "natural", or Items 23a or 28a-1 ehow the Medical Evertirer roual be rotified at	Ď	3 ☐Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 X No	Specify:			Specify: With	nite
Q 2	72 ho	Completed	15. Decedent's (Specify only highest		16a. [Decedent's Us	ual Occupa	ition	-4. advisa	16b.	Kind of Business	
2	ithin	nple	Elementary/Secondary (0-12)	College (1-4or		Give kind of w life. DO NOT	use retired) most o	or working			
2	led w lygier her th			6	Mat	hemati	cal S				ensus Bu	reau
anc	ntal h	Be	17. Father's Name (First, Middle, La	-					s Name (First, M			
Ž	hould Me	ပို	Rolland Cecil 19a. Informant's Name/Relationshi		10h I	Mailing Addray	o (Campa) o		a Paulin		herland or Town, State,	71.0.4.
Σ	treu	i	Marjorie D. Wo									Zip Code)
Battimore, Maryland	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or items 23a or 28a-f ehow any injury or other treumatic event, the Medical Examination at any ange.		20a. Method of Disposition		20b. Place of D	Disposition (Na	ame of		nham, Ma Date		d 20706 Location - City or	Town, State
Ë	Page lent o nt: If ry or		1 M Burial 2	☐Removal from State cify)	Fort Li	crematory or			1/7/2006	D.	rontrood	Morrel on J
att	permit. Departminports Imports any inju		21. Signatury of Funeral Service U	censee					Gasch'	s Fun	eral Hom	, Maryland
<u> </u>	88 5 8		Ment Tale	ellen	6						ille, MD	
			23a. Art1. Enter the disease, or c	omplications that cause	d the death. Do no							Approximate Interval Between
y	Physician		Immediate Cause (Final disease or condition		lial Infa	rction						Onset and Death 45 Minutes
	/Medical Examiner		resigniting in death)	Due to (or as	a consequence of):						45 Minutes
	LXdiffile	ايا	Sequentially list conditions,	b. Arrhyth								45 Minutes
	ted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):						
	al-tra	xar	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):						
8760,	icate be executed physicien end s the burial-transit	dical		d								
9	tificat ig phy as th	edi										
XO	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death	3 □Ectopic p	vecus and				23d. Date of de	livery
о. В	e dea he at	sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant a 9☐Unknown		5 Other (s					Month	Day Year
<u>Ч</u>	that the de led by the a detached f	Phy	9 Unknown									
Records,	The law requires that the death certificate be executed the has been signed by the attending physicien end age 2 should be detached for use as the burial-transit	by	Part II. Other significant condition	s contributing to death t	out not resulting in t	ne underlying	cause give	n in Part I.				o the cause of death? Tobably 4 X Unknown
Sec.	elaw hasb je2st	Completed								Was an autopsy	prior to	utopsy findings available completion of cause of
										performed? ′es 2∭1		2 🗆 No
Ž	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe		f Death Check of			
ot	Phys r this ral di	5	1 ☐ Yes 2 🛣 No 27. Manner of Death	1 U Inpati				4 🗀 19015			6 □Other (Spe	cify)
O	ding th. : Afte	tlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Inju (Month, Da	y Year) Inji	ury M	28c. Injury Work 1 □ Y	? ′es 2 ⊡No		noe now in	ury occurred	
Division of Vital	Attending r death. ctor: After by the fune	Certification:	3 Suicide 6 Could no determin	t be 28e. Place of In	ury - At home, farm	n, street, facto			28f. Locat	ion (Street	and Number or Ri	ural Route Number,
ā	s after s after al Dire	Cert	4 Homelae	building, et	c. (Specify)				City o	r Town, Sta	ite)	,
	To the Mospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best animer. On the basis of and manner st	r examination and	death occurred or investigation	d at the time	e, date and inion, death	place, and due to occurred at the t	the cause me, date a	(s) and manner as nd place, and due	s stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	11	1/	29	c. License	number		2 9 d. D	ate signe (Mont	h, Day. Year)
			Shintell	Jun 1		1	D2	7824			1/1/2	/
1	(10)		30. Name and a Wess of person w	/		ype, may	7				11/00	27
. S.			Elizabeth Susar 31. Date filed (Month, Day, Year)			or's C	ommun	ity H	ospital,	Lanh	am, Mary	land
	Sta Registr	100	JAN 0 5 2006		ar's Signature	10						

State of Maryland / Department of Health and Mental Hygiene n For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 13, 2006 Sealman Paul Yancey Jr. January 6:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday)
72 Yrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** # M 2 | F Months Days Hours Min Yrs Director 218-28-7335 11/02/1933 VA Usual Residence of Decedent the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Madical Exerteinar must be notified at by Funeral Director MD Carroll 1 ☐ Yes 2 # No Hampstead 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? , or iteme 23a 3796 Castle Dr. 21074 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 1955 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes 2 # No Specify Specify: White 3 Widowed 4 Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Spice Co 3 Corporate Sanitarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill tment of Health and Mental H tant: If item 27 is marked other. Be Sealman Paul Yancey Sr. Freda Florence Weddle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) operation of Health are apportant; if item 27 is not injury or other in it. Mary Ann Yancey Wife 3796 Castle Dr. Hampstead MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
any injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley 01/17/2006 Timonium MD 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee Xleven M00723 934 South Main St Hampstead MD 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Oncet and Death Immediate Cause (Final disease or condition resulting in death) **Physician** da /Medical Due to (or as a con-Examiner in Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a co The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy ò Year Month Day 4☐Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 1 Yes 20 NO Division of Vital To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: Atter this certifice 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 No 1 Tes 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier ddress of pe o completed cause of death (Item 23a) (Type Print) son : CN Ì

State Registrar 31. Date filed (Month, Day,

2006

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		For State Registrer		aryland / Dep		Health and M Death	ental Hyg	
	Ä,	1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath 3. Time of Death
Physicia /Medica		Her	bert M.	Avram			Month (2)	Day Year 9:30a.M
Examine	_	4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death		4c. County of Death
		44041 Fieldstone	Way		Cal:	ifornia		St. Mary's
Funeral		Social Security Number 6. Security Number	5	в (In yrs. last birthday	If Under 1 Year Months Days		8. Date of Birth (Month, Day	
Director		123-07-1100	MM 2□F	92 Yrs.			January 2	4, 1913 New York
and *	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation			10d. Inside City Limits
Maryl f sho	5	Maryland St. Man	ry†e	Calif				1 ∑Yes 2 □ No
the 1	rect	10e. Street and Number	Ly 3	Calli	10f. Zip Code			10g. Citizen of What Country?
a with	<u> </u>	44041 Fieldstone	Wav			619		United States
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23a or 28a-1 show ont, the Medical Evanifrer must be rediffed at	by Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S. 13.		Hispanic Origin? (Spe pan, Mexican, Puerto I	-	
entrer after	F	1 ☐ Never Married 2 Married	Armed Forces? 1 X Yes 2 ☐ f If Yes, Give	√o WWII			Rican, etc.)	
ours Fra	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 ☐ Yes 2 🎇 No	Specify:		Specify: White
72 h 72 h	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece	edent's Usual Occu	pation during most of workit ed)	ng	16b. Kind of Business/Industry
Within Ne. Ne. Ne. Ne. Ne. Ne. Ne. Ne. Ne. Ne.	dm	Elementary/Secondary (0-12)	College (1-4or 5	+)		9d)		United States
Maryland 21215-0036 nd 2 should be filed within 72 hours aff the and Mental Hygiene. 27 is marked other then "natural", or traumatic event, the Medical Evant		17. Father's Name (First, Middle, Last)	4	Anal	yst	18. Mother's Name	/First Middle	Government
and libe f ed of ed of	Be	Mois H. Avram				Ernesti		
hould d Me mark mark	2	19a. Informant's Name/Relationship (7	voe Priot)	10h Mail	ing Address (Stree	1		r, City or Town, State, Zip Code)
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Evantral must be notified at	- 1	Henriette D. Avra	•		-			nia, Maryland 20619
1 an 1 an Heal tem 2		20a. Method of Disposition	m / WITE	20b. Place of Disp cemetery, cre			attrori	20c. Location - City or Town, State
Pages nent of lint: If its		1 Burial 2 Cremation 3		Montgomery		_ Ouride	ery 20,	
Baltimore, permit. Pages 1 a Department of Her mportant: If item any injury or othe		*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License						Bethesda, Maryland
Balt permit. Departr Importa any inji		Mar State Denne	1	M01305 3	bert A. Pu	mphrey Funer	al Home/R	Rockville, Inc.
		23a. Part1. Inter the disease, or comp shock or heart failure. List only of	dications that caused					11e, Maryland 20850-2805
		shock/or heart failure. List only o	one cause on each lin	19.				rest, Approximate Interval Between Onset and Death
Physician / /Medical	İ	disease or condition resulting in death)	a. Pul	monave	1 Fil	2,501		
Examiner			Due to (or as	a consequence of):	J			
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):				
uted d ansit	Examiner	Cause (Disease or injury that initiated events						
exec exec in an	Exa	resulting in death) Last	Due to (or as	a consequence of):				
Records, P.O. Box 68760, The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ca		d					
68 tifica ng ph as th		le e-viv e						
Box 68 eath certific attending p	Physician/Med	23b. was decedent pregnant	23c. If yes, outcome		⊒Ectopic pregnanc	·v		23d. Date of delivery
death death	SICI	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown		Other (specify)			Month Day Year
P.O	hy	9 🗆 Unknown						
ds, P.O. I	þ	Part II. Other significant conditions co	ontributing to death b	ut not resulting in the	underlying cause gi	iven in Part I.		obacco use contribute to the cause of death?
Records,	ted						1 🗆 Y	′es 2 No 3 Probably 4 Unknown
Peco e taw r has be	Completed						24a. Was a autop	
	Con						perfor	med? death? 2XNo 1 Yes 2 No
of Vital F Physician: Th rthis certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of Death	(Check only or	ne)
	2	TLI TOS ZIXINO	Hospital: 1 ☐ Inpatie		III JUDOA			lence 6 Other (Specify)
ing P	Certification:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time Injury	Wo		28d. Describe h	ow injury occurred
Vision Attending r death. ector: After	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No		
Division or Attending after death. Director: After tin by the fune	rtit	4 Homicide determined	building, et	ury - At home, farm, s c. (Specify)	reet, factory, office	,	City or Tow	Street and Number or Rural Route Number, m, State)
pital burs a burs a eral i		200 Cartifies 17 Cartifying Phy	valeion. To the best	of much manufacture of manufacture o			4.1	
Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the best siner: On the basis of and manner sta	examination and/or i	in occurred at the to restigation, in my	opinion, death occurre	and due to the d ad at the time, d	cause(s) and manner as stated. date and place, and due to the cause(s)
o the ithin (o the omple	Med	29b. Signature and title of certifier	und mainer St	nod.	29c. Licen	se number	2	29d. Date signed (Month, Day, Year)
F ≥ F 8			M			005575		1-15-06
-11		30. Name and saless of person who d	completed cause of d	eath (Item 22a) (Time		,000,13	1	
101,		Jennifer Schmidt,				fornia. Ma	rvland	20619
Stat	te	31. Date filed (Month, Day, Year)		ar's Signature	, 0411			
Registra		JAN 2 4 2	006	K d	lived o			

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			For State Registrar	State of Marylan		artment of He			giene	ne. 06 01476
	Physici /Medi		1. Decedent's Name (First, Middle, Las	Alked				2. Date of Dea Month JAN		Year 3257 M
	Examir Funeral Director	ner	5. Social Security Number 6. S	spice contra	last birthday) Yrs.	4b. City, Town, or Lo	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		9. Birthplace (State or Foreign
	D	ctor	Usual Residence of Decedent 10a. State 10b. County MD N	10c. Cit	y, Town or Lo	ocation Timore		1100 [1	, 1939	10d. Inside City Limits 1
9	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mentait Hygiene. Item 27 is marked other than "natural; or items 23s or 28s-f show other traumatic event, the Madical Examinar rutal be notified at	Funeral Director	10e. Street and Number 3601 Souther 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No		10f. Zip Code 2 Was Decedent of Hisp If Yes, specify Cuban,			14. Race	/hat Country? S. A. - American Indian, c, White, etc.
1215-0036	within 72 hours ene. then "neturel", in Madical Exe	Completed by	3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	16a. Dece	denl's Usual Occupation kind of work done dur DO NOT use retired) Secretch	ring most of worki	ing	Specify:	siness/Industry
Ē	should be filed with nd Mental Hygiene, marked other the umatic event,	To Be Co	17. Father's Name (First, Middle, Last) Domenic Meni 19a. Informant's Name/Relationship (1)		19h Maili		B. Mother's Name	is Un	Maiden Sumame	9)
a)	Pages 1 and 2 sho lent of Health and int: if item 27 is m iry or other traum		20a. Method of Disposition 1 Burial 2 Cremation 3 D 4 Donation 5 Other (Specify	Removal from State	Place of Disposemetery, cres	sition (Name of matory or other place)	n Ave.	balto I	W 212	City or Town, Slate
Balti	permit. Pages Depertment of important: If it any injury or o	·	21. Signature of Funeral Service Licen 1	See Colors that caused the deat	2	PAUL ST	so po.	PRAI bte	me PA	Approximate
	Physician // Medical Examiner and prize portal tube prize tube prize tube prize tube prize tube prize	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	uence of).	st Ca	n cel	2		Interval Between Onset and Death
P.O. Box 6	at the death certifica by the attending ph tached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, oulcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I déath 3[eath 5[Ectopic pregnancy Other (specify)			23d. Date Mont	o of delivery th Day Year
Vital Records, F	lew requires that as been signed 2 should be de	Completed by F	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause given	in Part I.	1 Your Year 24a. Was a autops perform	es 2 No 3	bute to the cause of death? 3 Probably 4 Unknown fere autopsy findings available ior to completion of cause of saih?
n of Vital	ing Physician: The n	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatient 2 Inpatient 2 (Month, Day Year)	ER/Outpatier 28b. Time o Injury	other: 28c, Injury at Work?	6. Place of Death	me 5□Reside	16)	
Division	To the Hospital or Attending Ph within 24 hours elter deeth. To the Funeral Director: After th completely filled in by the funeral	I Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	y) 	eet, factory, office		City or Town	n, State)	r or Rural Route Number,
	To the Hos within 24 hc To the Fun	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Ph. 2 ☐ Medical Exam 29b. Signature and title of certifier	ysician: To the best of my kno iner: On the basis of examina and manner stated.	ition and/or in	vestigation, in my opini	ion, death occurre umber	ed at the time, d	ate and place, ar	nd due to the cause(s) (Month, Day, Year)
7	Sta Registi		30. Name and address of person who all the state of person	GMC 67	21/	Print) Charles	St. 9	rolts.	md Z	1206
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		_	YLOR Unpend item#2 1 - State Registrar		·iai yldi		tificati					Rag. No	7111	06	01477
	sicia	_	Decedent's Name (First, Middle, La Lakeshia	ast)	D.		В	aylo	or		2. Date of De Month JAN.		200	O6	3. Time of Death 11:10A
<i>*</i> -	ledic imin		4a. Facility Name (If not institution, gir 3 VENUS COURT AP	_	er)		•	Town, or	Location	of Death	O.L.	4c.	County	of Death	1
Fune Direc			5. Social Security Number 6. 21886-7641		Age (In yrs. 32	last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bi. (Month, Di. 2-2	th			nplace (State or Foreign untry) Md.
faryland	12.01	ō	Usual Residence of Decedent 10a. State 10b. County Md. Baltir	nore	10c. Ci	ty, Town or Lo	cation WSON						**		10d. Inside City Limits
h the h		irect	10e. Street and Number				10f. Zip	Code				10g. Cit	izen of \	What Co	
th wit	181	aiD	3 E. Venus Cour	ct Apt.	E				2123	4			USA		
permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mential Pygiene. Important: if item 27 is marked other then "naturel", or iteme 23a or 28a-f ehow		by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 21 If Yes, Give Year or Date	is? ∑ No		Was Deced f Yes, spec I ☐ Yes 2				ecify Yes or No Rican, etc.))-		ck, White	ican Indian, , etc. Black
nd 2 should be filed within 72 hours aft lith and Mental Hygiene. 27 is marked other then "naturel", or	Manifest	Completed	15. Decedent's E (Specify only highest gi	Education rade completed) College (1-40	or 5+)	iire. i	kind of wor DO NOT us	rk done d se retired	luring mos)	st of worki	ing			usiness/l	
Hygier ther ti	i i	S	12th grade 17. Father's Name (First, Middle, Las	t)		Ser	vice	Mana		ar's Name	e (First, Middle		-Mar		
ould be Mental	A Silve	To Be	Daryl		E	Baylor			(Gale				Tuc	cker
d 2 sh th and 7 is m	Trent.		19a. Informant's Name/Relationship Gale E. Tucker		cher	4					<i>iR</i> oute Numb et, Bal				
Depertment of Heel	ry or other		20a. Method of Disposition **Disposition** **Dispositio	Removal from Sta	20b. I	Place of Dispo cemetery, cren Cing Me	sition (Nam	ne of ther place			Date	20c. Lo	cation -	City or 1	21229 Town, State
permit. Depertm	ony min		21. Signature of Funeral Service Life		kı		. Name and				B 1101	alti E. N			
/Medi Examir	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the ettending physician and positive completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or pure the complete or the funeral director.	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	as a consec as a consec as a consec	quence of):									15494 - OX
Attending Physician: The law requires that the death certificate be executed rideeth. extor: After this certificate has been signed by the eltending physician and the the contrinued of the signed by the distanced for use on the build has distanced for use on the build has distanced.	cied los use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 X Unknown	23c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown	2 ☐ Feta at time of c	al death 3	Ectopic pre						23d. Dat Mo	te of deliv	very Day Year
The law requires that the death certific the law requires that the death certific the las been signed by the ettending page 2 should be detached for use 2	90 90 900		Part II. Other significant conditions	contributing to death	but not res	sulting in the ur	derlying ca	ause give	on in Part I			obacco u Yes 2		ribute to	the cause of death?
The law recete hes be	2 0 0 0 0	Completed					-	-	·				, c	prior to co death?	opsy findings available ompletion of cause of 2 No
sician	200	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o				
l or Attending Physician: 1 ster deeth. Director: After this certifical	8	ation: To	1 N Yes 2 No 27. Manner of Death 1 N Natural 5 Pending 2 Accident investigation	28a. Date of Ir (Month, L		28b. Time of Injury		Bc. Injury Work	4 🗆 190	2	ne 5 Resi				M AT SCENE
tal or Atters de al Directo	n ka	Certification:	3 Suicide 6 Could not t 4 Homicide determined	286. Place of	Injury - At h etc. <i>(Speci</i> i	ome, farm, stre	eet, factory,	, office		2	28f. Location (: City or Tot	Street an vn, State	d Numb	er or Rur	al Route Number,
To the Hospital within 24 hours E To the Funeral i	Dieleiy III	edical	29a. Certifier 1 ☐ Certifying P. (Check only one) 1 ☐ Madical Exa	hysician: To the be miner: On the basis and manner	of examina	owledge, death ation and/or inv	occurred a estigation,	at the tim in my op	e, date an inion, dea	d place, a th occurre	and due to the ed at the time,	cause(s) date and	and ma place, a	nner as	stated. to the cause(s)
Tot Tot	3	Σ	29b. Signature and title of certifier	mid			29c.	O.C	number .M.E				_	(Month,	Day, Year) 006
			30. Name and address of person who	mino	13	L1 PENN	STRE	ET,	BALT	IMORI	E, MARYL	AND	2120)1	
Reg	Stat gistra	-	31. Date filed (Month, Day, Year) JAN 2 4		tràr's Signa	ature	Carle	,							

			For State Registrar	State of Maryland	-	rtment of			giene Reg. No.	006	01478
			1. Decedents Name (First, Middle, La	51)				2. Date of Dea	ath		3. Time of Death
	Physicia /Medic		YAUL J.	BENEDETTI	4 5	R.		JANUA!	RY 2:	Year 3, 2006	3:00 AM
	Examin		4a. Facility Name (If not institution, give			4b. City, Town	, or Location of Dea		4c. C	ounty of Death	
L			Saint Joseph			W.11-1	Tows				imore
	Funeral		5. Social Security Number 6. S		15 Yrs.	Months Day			v. Year)	l Ga	pplace (State or Foreign
	Director		Usuel Residence of Decedent	/	J			11/1	/193	0 11	MANU
	yland		10a. State 10b. County	10c. Pity	Town or Loc	cation					10d. Inside City Limits
	a-f si	ctor	MD BALTIM	IORE IF	RKV.	TLLE					1 ☐ Yes 2 ☐ No
	ith th	Director	10e. Street and Number	Λ		10f. Zip Code)			on of What Co	untry?
	ath w 23a	2	3017 HISS	HUE.		día	34			JSA	
	er de Iteme	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S Armed Forces? 1 179s 2 No	5. 13. V	Vas Decedent o Yes, specify C	f Hispanic Origin? (: uban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 14	 Race - Amer Black, White 	
36	irs aft	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐Yes 2☐K	lo Specify:		s	pecify:	4176
1215-0036	tiled within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Iteme 23a or 28a-f show ant, the Mydical Examiner must be notified at	ted	15. Decedent's E	ducation	16a. Deced	ent's Usual Occ	cupation		16b. Kind	of Business/I	
215	thin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	O NOT use reti			1		
	filed wi Hygien other th	Con	6		IILE S	SETTER &	FINISH		حن	NSTRU	ICTION
D D	tal H d ott	Be	17. Father's Name (First, Middle, Last,				~	ime (First, Middle,	Maiden S	umame)	
⋛	2 should be and Mental is marked of aumatic eve	ို	19a. Informant's Name/Relationship (ENEDE'TTA	10h Mailin	a Address (Ctro	net and Number or R		1 141	(ALLA	"- Code \
Maryland 2	0 a = a		MARIE BENED	. ,	30. Walling	1/	ISS AVE.	//		my	
ନ୍	s 1 and f Health Item 27 other to		20a. Method of Disposition	20h Pla	ace of Dispos	sition (Name of		Date		ation - City or	
Ë	Pages nent of int: If It iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	ANEY	VALLE	JUDEN OK,	2006	Tim	oNIUM	mD.
altimore,	permit. Pages Depertment of Important: If I any Injury or one		21. Ignature of Forer Service Lice	. 1	22	. Name and Add	dress of Facility	IANS F		AL CH	
m —	8858		1 Ktato.	Dudelmy	1 8	800 H	ARFORD	RO. Pr	arku.	ILE, P	10 21254
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dath. one cause on each line.	. Do not ente	er the mode of o	lying, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a CEREBROVAS	SCULA!	R ACCI	DENT				Onset and Death
	/Medical Examiner		resulting in dealin)	Due to (or as a consequ	ence of):						
		<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. Due to for as a consequ	anea off.						
	uted 3 anslt	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		•						
o`	exec an an	Exa	resulting in death) Last	C. Due to (or as a consequ	ence of):						
8760,	cate be executed physician and the burial-transit	dlcai		_ d							
Ó	leath certifice attending ph for use as t	Med	IF FEMALE:		-						
Box	ath ca	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregna			23	d. Date of deli Month	very Day Year
o.	he de	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of de 9☐ Unknown	iatn 5∟	Other (specify)					
۵.	The law requires that the death certific site has been signed by the attending p cage 2 should be detached for use as		Part II. Other significant conditions	contributing to death but not resu	Iting in the ur	nderlying cause	given in Part I.	23e. Did t	obacco use	e contribute to	the cause of death?
rds,	n sign	ed by	CHRONIC OBSTRUCTI	VE PULMONARY DI	SEASE			10	Yes 2	No 3□Pro	obably 4 Unknown
000	aw require s been si 2 should b	plete						24a. Was	an	24b. Were au	topsy findings available
<u>~</u>	The I	Completed						autor perfo	osy omed? 2A No	death?	completion of cause of
ita	ctor, 1	Bec	25. Was case referred to medical examiner?				26. Place of De	eath (Check only o			
<u>></u>	Attending Physician: r death. ector: After this certifici by the funeral director.	မှ	1 ☐ Yes 2 No		ER/Outpatien	1 3 DOA		Home 5 ☐ Resi			erfy)
Ę	Sing F	ion:	27. Manner of Death 1. Natural 5 ☐ Pending	(Month, Day Year)	28b. Time of Injury		yury at Vork?	28d. Describe	how injury	occurred	
Division of Vital Record	death death ctor:	lcat	2 Accident investigation 3 Suicide 6 Could not be	99 Place of Laiun, At he	me farm str		☐Yes 2☐No	28f Location (Street and	Number or Ru	ral Route Number,
<u>></u>	after Dire	Certification;	4 ☐ Homicide determined	building, etc. (Specify)	, iadio. y, on.		City or To	vn, State)		
	To the Hospital or Attending Physician: The law Within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 12 Certifying Pl	hysician: To the best of my know	wledge, death	occurred all the	i tima, data and plac	tal and due to the	causi(s) a	nd manner as	stated
	the Hi in 24 the Fi	ledical	Olie)	miner: On the basis of examinat and manner stated.	ion and/or in	restigation, in m	y opinion, death occ	curred at the time,	date and p	nace, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. Lice	ense number		29d. Date	signed (Month	* * * * * * * * * * * * * * * * * * * *
)	~			and the			37254		1	23 6	6
	10		30. Name and address of person who	completed cause of death (Item	23а) (Туре,	Print)					
	Sta	to.	31. Date filed (Month, Day, Year)	32. Registrar's signat	100	JVE TO	MSON MAI	RALUMD	2127	4	
	Registi		JAN 2 4 2006	Breve to 1	7						

			1 - For State of Maryland / [Department of Health of Certificate of Death		al Hygiene	006 011.70
	Physici	an	Decedent's Name (First, Middle, Last)			ate of Death	3. Time of Death
5	/Medic	al	Alice Rachel Baumgartner			nuary 2	20, 2006 5:15A ^M
	Examin	er	4a. Facility Name (If not institution, give street and number) Continuum Care	4b. City, Town, or Location		4c.	County of Death
4.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bin	Sykesv nthday) If Under 1 Year If Under	r 24 Hrs. 8. Da	ate of Birth	9. Birthplace (State or Foreign Country)
	Director		217-24-1330 1 T X 78	Yrs. Months Days Hours		n 17, 1	928 MD
	and **		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Location			10d. Inside City Limits
	Maryl f aho	tor	MD Carroll	Westminster			1 ☐ Yes 2√2 No
	r 288.	irec	10e. Street and Number	10f. Zip Code		10g. Cit	izen of What Country?
	th with	Funeral Director	2844 Old Washington Road	21157			USA
	er dea	uner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Or If Yes, specify Cuban, Mexican 	rigin? (Specify Y n, Puerto Rican,	es or No- , etc.)	14. Race · American Indian, Black, White, etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes A☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	re *		Specify: White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or itams 23e or 28e-1 ahow he Mcdical Examinar must be notified at	ted	15. Decedent's Education 16a	. Decedent's Usual Occupation		16b. K	ind of Business/Industry
215	thin 7 e. an "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during mos life. DO NOT use retired)	st of working		
	filed wi Hygien other th			dministrative			
Maryland	ntal H ed ott	Be o	17. Father's Name (First, Middle, Last) Murray Sherman Hinton		_{sy Ster}	t, Middle, Maiden	Sumame)
Ž	should and Men marke umatic	T _o		DATE DATE			or Town, State, Zip Code)
	and 2 sealth ar			80 Windriver D			
altimore,	es 1 a of He f itam r othe		Cemete	of Disposition (Name of ary, crematory or other place)	Date		ocation - City or Town, State
Ē	Pages ment of I tant: If its jury or o		`4 □Donation 5 □ Other (Specify)	County Crematic	on 1/22	2/05 Sy	kesville MD
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depurment of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural; or itams 23a or 28a-1 show any njury or other traumatic event, the Medical Examinal must be notified at once.		21. Signature of Furgral Service Licensee	Sykesville ,	MD 217	78 4 (4 1	APEL (Box 195) 0)-795-1400
U			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as	s cardiac or resp	iratory arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)				2-3 mos.
B	Examiner		Due to (or as a consequence	of):			E Chieron Service
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	of):			10000
	cuted nd transit	Examiner	that initiated events c. Urina tro				1 week
90	cate be executed obysician and the burial-transit		resulting in death) Last Due to (or as a confequence	of):			
68760,	death certificate be executed e attending physician and of for use as the burial-transii	edicai	d				
Box (eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date of delivery
		Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown	n 3 □Ectopic pregnancy 5 □ Other (specify)			Month Day Year
P.O.	by by	Phys	9 Unknown			0.00	
	signed d be del	by	Part II. Other significant conditions contributing to death but not resulting i	n the underlying cause given in Part I	1. 2	3e. Did tobacco t	use contribute to the cause of death?
Vital Records,	v requir been si should	Completed	2 page 10			4a. Was an	
Rec	The lav	dmo				autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
ta	10	0	25. Was case referred to medical	26. Plac	e of Death (Che	Yes 2X No	1 ☐ Yes 2 ☐ No
Ę.	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatrent 2 ☐ ER/Ot	0.1			6 □Other (Specify)
n of				Time of 28c. Injury at Injury Work?	28d. D	Describe how injur	
sio	Attending r death. actor: After	icati	2 Accident investigation	M 1 Yes 2		acation (Street as	ad Alumba and Dural Davida Mumbas
Division	for Attendate after death	ertification:	4 Homicide determined 28e. Place of Injury - At home, to building, etc. (Specify)	arm, street, ractory, onice	281. CC	ity of Town, State	id Number or Rural Route Number,)
	Hospital or 24 hours afte Funeral Dir tely filled in	O	29a. Certifier 1 Certifying Physician: To the best of my knowledge	e, death occurred at the time, date ar	nd place, and du	ue to the cause(s)	and manner as stated.
	To the Hospital or At within 24 hours after of To the Funeral Dirac completely filled in by	edical	(Check only 2 Medical Exeminer: On the basis of examination ar one) and manner stated.	nd/or investigation, in my opinion, dea	ath occurred at t	the time, date and	d place, and due to the cause(s)
	To the within 2. To the complet	Σ	29b. Signature and title of certifier	29c. License number		3	te signed (Month, Day, Year)
(n a		KWeishalans	D00629	75	1/2	0/06
	0) 8		30. Name and address of person who completed cause of death (Item 23a)		Che - : - n	in- 111	71167
	Sta	te	31 Date filed (Month) Pay Year) 32 Cistrar's Signature	Ave #301, We	SUINITS	14 POID	413/
	Registi		JAN 2 4 2006 Shave B	Marke			

			State of Maryland / Dep	ertificate of Death	100 01400
		4	Decedent's Name (First, Middle, Last)	2. Date of Death Month	3. Time of Death
	Physici /Medic		James Andrew Baker	Jan. 20	, 2006 5:05p M
	Examir	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			3237 Kensington Court	Manchester	Carroll
1/2	Funeral Director		5. Social Security Number 6. Sex 1 Nm 2 F 7. Age (In yrs. last birthday 81 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y. Aug 12	9. Birthplece (State or Foreign Country) , 1924 MD
	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or it	ocation	10d. Inside City Limits
	haryli •ho	ō	MD Carroll Manche		1 Tes 2 No
	the N	Funeral Director	10e. Street and Number		. Citizen of What Country?
	with p of	ā		21102	USA
	eath	era	3237 Kensington Court 11. Marital Status 12. Was Decedent Ever in U.S. 13		14. Race - American Indian,
40	ther d	Fun	Armed Forces? 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
336	ours after death with the Marylar rel', or Items 23e or 28e-f ehow Exaculoer coast be notified at	by	1 □ Never Married 2 ሺ Married 1 1 □ Never Married 2 ሺ Married 1 1 □ Never Married 2 □ No HYes, Give WWII	1 ☐ Yes 2 🔀 No Specify:	Specify: White
21215-0036	within 72 hours after death with the Maryland ene. then 'naturel', or Items 23e or 28e-f ehow the Molicel Exaction could be notified at	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation 16	b. Kind of Business/Industry
218	hin 7	ple	(Specify only highest grade completed) (Giv Elementary/Secondary (0·12) College (1·4or 5+)	e kind of work done during most of working DO NOT use retired)	
21	gien gien	NO.	12	Printer	Printing
pu	be filed ital Hygid of other event, II	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Ma.	iden Sumame)
Va	ould be Mental mrked o	2	James Baker	Aleatha	
Maryland	2 shc and and le ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mai Mrs. Christine Baker (Wife) 32	ling Address (Street and Number or Rural Route Number, C	
	1 and 2 Health tem 27				
ore	of H		I Abunai 2 i Cremation 3 i Premovalitom State i	ematory or other place)	c. Location - City or Town, State
Ë	Pag tment tant: jury				arriottsville, MD
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 Ie marked other then eny Injury or other traumatic event, Ita M once.		BUNK C. MULGY S	Alghi Funeral Home & Ci ykesville, MD 21784 (4	10)-795-1400
	Pnysician /Medical Examiner	e.	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate.	Mel Awa Ma Mel Awa Ma Mestra Ses-	, Approximate Interval Between Onset and Death
68760,	es that the deeth certificate be executed igned by the attending physician and be detached for use as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Uniscase or in Jury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):	url	
P.O. Box	law requires that the deeth certifica es been signed by the attending ph 2 should be detached for use as it	Completed by Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
	w requires that been signed I should be det	ed by P	Part II. Other significant conditions contributing to death but not resulting in the	011.	co use contribute to the cause of death? 2 No 3 Probably 4 Junknown
Vital Records,	The ate h	Complet		24a. Was an autopsy performe 1 □ Yes 20	24b. Were autopsy fi dings available prior to completion of cause of death? No 1 Yes 2 No
/ita	ding Physiclen: Thi n. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death Che k o one	•
5	Physic this c	ဥ	1 Tes 212 No 1 Inpatient 2 En/Outpatie		e 6 Other (Specify)
n c	fter fter	on	27. Line of eath 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work? M 1 Yes 2 No	injury occurred
Sic	uttendi death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be		et and Number or Rural Route Number,
Division of	or A after Direction by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	City or Town, S	
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical Co	29a. Certifier (Check only one) 2	an occurred at the time, date and place, and due to the caus investigation, in my opinion, death occurred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	To the To the comple	Me	29b. Signature and trie of certifier	29c. Proense number 29d	Date signed (Month, Day, Year)
	1)			10001	1/23/06
	4		30, Name and addres of person to completed cause of death (Item 23a) (Type	Center Street Wisten Wisten	1121157
	- I I I I	ate	31. Date filed (Month, Day, Year) 32. Rigistrar's Signature		'LIDGELD'
	Regist		JAN 2 4 2006	adi)	
DH	IMH 17 Rev 1/2	AL UNIO	JAN 4 4 COUD JOHAN SE P		

ORIGINAL

			For State Registrar		State of	f Marylan		artment o <i>rtificate</i> (Mental H	ygien Reg. N	2111	16	0 481
	Physic /Med		Decedent's Name	e (First, Middle, La		Barbash	ı				2. Date of D Month Janua:	eath D	ay	906	3. Time of Death 7:05 AM
	Exami		4a. Facility Name (II Suburbar	not institution, giv 1 Hospita		nber)		4b. City, Tow Be t	m, or Location	n of Death			c. County		
	Funeral Director		5. Social Security No. 111-03-23	389	Sex 1□M 2⊠F	7. Age (In yrs. 91	last birthday) Yrs.	If Under 1 Y		Min.	8. Date of B	irth		9. Birthp	place (State or Foreign ntry) 1ecticut
	ryland		Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or Lo	ocation						1	10d. Inside City Limits
	Ba-f	cto	Maryland	Montgom	nery		Ro	ckville	9						1 ☐ Yes 2 🙀 No
	with th	Dire	10e. Street and Num					10f. Zip Coo					itizen of V		•
	eath w	Funeral Director	11. Marital Status	trose Ro	_	dent Ever in U.	6 12		20852)-i-i-0 (0-	- 4	L	ted S		
21215-0036	72 hours after death with the Maryland natural', or iteme 23e or 28e-f ehow dical Examil at must be rotified at	þ	1 Never Marrie		Armed For 1 Yes If Yes, Give Year or Da	ces? 2 🌠 No e		Was Decedent If Yes, specify (1 ☐ Yes 2 ☑	Cuban, Mexic	an, Puerto	еслу Yes or N Rican, etc.)	0-		k, White,	ean Indian, etc. hite
5-0	72 hours "natural",	eted	(Speci	15. Decedent's En	ducation		16a. Dece	dent's Usual Oc	cupation	at of words	·	16b. I	Kind of Bu		
121	filed within Hygiene. ther then out, the Men	Completed	Elementary/Secon		College (1-	4or 5+)		kind of work do DO NOT use re	tired)	ISI OF WORK	ing				
2	filed v Hygie ther t	ပိ	12 17. Father's Name (First Middle Last			поп	emaker	10 14-1		· · · · · · · · · · · · · · · · · · ·		wn Ho		
Maryland	12 should be filed within 'n and Mental Hygiene. 7 le marked other then "r	To Be		lube1bank							e (First, Middle th Hart			e)	
ary	should Mind Mind Mind Mind Mind Mind Mind Min	-	19a. Informant's Na				19b. Mailir	ng Address (Str						State Zin	Code)
	and 2 salth a n 27 te		Fred Barb	ash/Son											C. 20016
Baltimore,	T T P			osition Cremation 3 5 Other (Specif		tate Mon	emetery, crer tgomer	sition (Name of natory or other y um, Inc	place)	Janua 200	ry 19,	20c. L Betl	ocation - 0	City or To	wn, State ryland
Bait	permit. Page Department of Important: If eny injury or once.		21. Signature on Fur	neral Service Licer	1500	M001	22	Name and Adbert A. 57 Wisco	dress of Faci	lity			.Be	thes	da-Chevy
	Physician /Medical Examiner	ner	23a. Part 1. Enter the shock, or frear Immediate Cause (Fdisease or condition resulting in death) Sequentially list our if any, leading to immorause. Enter Under Cause (Disease or in Cause)	Final	Due to (c	used the death ich line. LTE or as a consequ LEUM or as a consequ	RESI	er the mode of	dying, such a	s cardiac o	r respiratory a	arrest,			Approximate Interval Between Onset and Death
68760,	ficate be executed physician and is the burial-transit	edicai Examiner	Cause (Disease or in that initiated events resulting in death) La		c	r as a consequ	ence of);								
P.O. Box (death certi e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?		th 2 ☐ Fetal nt at time of de	death 3	Ectopic pregna Other (specify)					23d. Date Mont		ry Day Year
	w requires that the been signed by th should be detache	þ	Part II. Other signific	cant conditions of	ontributing to dea	ath but not resu	lting in the ur	derlying cause	given in Part	l.	23e. Did t				e cause of death?
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Vit.	Physician: this certificatal director, i	Be	25. Was case referre examiner?		Hospital: 1			1 ,		e of Death	Check only o	опе			ZV
ō	Phys r this ral dii	P.	1 ☐ Yes 2 ☐ N 27. Manner of Doarh	0	Hospital: Inj		R/Outpatient 28b. Time of	3L DOX			ne 5 Resid)
on	Attending r death. ector: After by the funer	ti Li	1 Natural 2 Accident	5 Pending investigation	(Month)	Day Year)	Injury	28c. In W	vork? □Yes 2□		8d. Describe I	now injur	y occurre	d	
Divis	el or Atten eller deat i Director: d in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place o	f Injury - At hor g, etc. (Specify)	me, farm, stre	et, factory, offic			8f. Location (S City or Tox	Street an wn, State	nd Number	or Rural	Route Number,
	To the Hospitel or Attending Ph within 24 hours elite death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 (Check only 2 one)	X Certifying Phy Medical Exam	vsician: To the b iner: On the bas and manne	is or examinati	vledge, death on and/or inv	occurred at the estigation, in m	tima data w y opinion, dea	ath occurre	nd due to the d at the time,	causa(s) date and	and main t place, an	net as sta nd due to t	ited. the cause(s)
)	To the To the Company of the Company	W	29b. Signature and ti	-	ma-	i M	1.D.		nse number - 27	660		29d. Dat	te signed ((Month, D	ay, Year)
	10		30. Name and add s Alpana Go	swami 🗸 M	ompleted cause .D. 1111	of death (Item:	23a) (Type, F Ville	Pike #G	-100,	Rockv	ille,	Mary	land	2085	52
Pill	Sta Registr	ar	31. Date filed (Month)	Day, Year) AN 2 4 20	100	eistrar's Signatu		W							
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Barbash, Kate

			1	For State Registrar	S	State of	Marylar		artment o				lental Hy	6"	000	Com.	011.00	
				Decedent's Name (First, Middle,	Last)				rimouto	0, 2	Joann		2. Date of De			<u>U</u>	3. Time of Death	-
		/siciar ledica		Loui	se	К.		Berger	•				Month Januar	y 22		_{9ar}	4:40 A M	
	Ex	amine		a. Facility Name (If not institution,	-				4b. City, To	wn, or	Location	of Death		4c.	County of			
	5	1		Ospice of Balti	More 6. Sex			Center last birthday	Tow If Under 1		If Under	24 Hrs.	8. Date of Bi		Balti		e place (State or Foreign	_
	Fun-			213-10-5847		2 CXF		38 Yrs.		ays	Hours	Min.	May 2	ay, Year)	917	Cour	ryland	
	land	=	-	Usual Residence of Decedent 10a. State 10b. County			10c. Ci	ty, Town or L	ocation							1	0d. Inside City Limits	_
	death with the Maryland	Ì		Maryland Balti	more		Pa	arkvill	le								1 □ Yes 2 ☐ X No	
	vith th	Financial Director		10e. Street and Number					10f. Zip Co	ode				10g. Citi	zen of Wha	t Cour	ntry?	
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~	`	9 1		1 ☐ Never Married 2 ☐ Marrie		Armed Force 1 ☐ Yes 2	s?	7.3.	Was Deceden If Yes, specify				Rican, etc.)	0-	Black,			
老		2	2	3 Widowed 4 □ Divorced		If Yes, Give Year or Date			1 ☐ Yes 2X] No	Specify:				Specify:	Wh	ite	
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		Boo		17. Father's Name (First, Middle, L	ast)	-				-CX			(First, Middle			ne.		
7	ylar Menta Arked	atic.	2	Charles W.		Kresp	ach				Lil'		Joh					
~	Mar 12 sh hand 7 ie m	E La		19a. Informant's Name/Relationshi		,	•		ng Address (S									
90	Baltimore, Maryland 212: sermit. Pages 1 end 2 should be filled within Deperment of Heelth and Mental Hygiene. mportant: if item 27 is marked other then	other	-	Ernest A. Berge 20a. Method of Disposition	r, J	<u>r</u>	Son 20b. 1	Place of Disp	Farley osition (Name	of			n Arn Date		Mary cation - Cit			_
1	Pages net of	20 70		1 ☐ Burial 2 ☒ Cremation : 4 ☐ Donation 5 ☐ Other (Sp.		noval from Sta	318	-	matory`or othe Service		· 1	1-23-	-2006	Tov	wson		Maryland	
[22]	Baltimore permit. Pages Depertment of H important: if its	eny inju		21. Signatu e of Funera Service L	icensee		,		2. Name and A								Home, Inc.	-
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				23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final	nly one o	tions that cau cause on eac	sed the deat h line.		г		g, such as	cardiac o	er respiratory a	ırrest,			Approximate Interval Between Onset and Death	
	Physic /Med			disease or condition resulting in death)	a		as a consec		Levic	2						-	2 weels	_
	Exami	ш.		Sequentially list conditions,	b	,	CM	L								4	years	
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	18760, cate be executed physicien and	ine pur			d.													
	c 68 ortifica ing ph	Med	200	IF FEMALE:	1													
	Box 68 eath certificate attending pl	ior use	2	23b. Was decedent pregnant in the past 12 months?	23c.	If yes, outco	1 2 ☐ Feta	al death 3[□Ectopic pregr					2	23d. Date o	f delive	ory Day Year	
0	the de	ched i	731	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnan 9□Unknow		leath 5{	Other (speci	fy)								
0	0. ≥ ÷	page 2 should be delached for use as	<u>.</u>	Part II. Other significant condition	s contrit	buting to deat	h but not res	sulting in the u	inderlying caus	se give	n in Part I		23e. Did	tobacco u	se contribu	te to th	ne cause of death?	1
bra	ords equire sen sig	Dino							-				10	Yes 2Ì	100 3[] Prob	ably 4 Unknown	
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	Vital F icien: The certificete	. page											1□ Yes	2 Linno	dea 1 🗆		2 No	
Se	of Vita Physicien: rthis certific	To Be	0	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hos	pital:	atient 2] ER/Outpatie	nt 3□ DOA	Othe			n <i>Check only</i> me 5 ☐ Resi		- Mother I	·C	1 la cCoi a	-
000	On of ding Phys h. After this	_ [27. Manner of Death 1 ☐Natural 5 ☐ Pending	1	28a. Date of (Month,		28b. Time o		Injury		7	28d. Describe			Specin	1) NOSPIG	-
2	VISION Attending	ine fu		2 Accident investiga 3 Suicide 6 Could no	ation		,	,	м		/es 2 □	No						
	Division of Vital i or Attending Physicien: T after death. Director: After this certificat	led in by the tunera		4 Homicide determin		28e. Place of building	Injury - At h , etc. (Special	ome, farm, st fy)	reet, factory, o	ffice		2	28f. Location (City or To	Street and wn, State	d Number (or Rura	l Route Number,	
	Division To the Hospitei or Attent within 24 hours after death To the Funerei Director:	pletely fille		29a. Certifier 17 Certifying (Check only 2 Medical E	Physici xaminer	ian: To the bi : On the basi and manne	s of examina	owledge data ation and/or in	h secured at to execute the second of the se	he tin my op	a, date an inion, dea	d place, t	and due to the ed at the time,	caus s(s) date and	and manni place, and	due to	ated. the cause(s)	3
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				Delevil		Y-C			Di	DD	5-19	26		da	n 2	2,	2006	
_	C			30. Name and address of person w	no comp	pleted cause	of death (Iter	п 23а) (Туре	Print)		(-	C.i.	B 04	1000		0	2006	_
		State		31. Date filed (Month, Day, Year)	, _	-	istrar's Signa	ature 🐔 🔒	10, U	VICE	1002	27	Hour	10000	74 /4	البيا	401	_
	Re	gistrai	-	IAN 2 4 70	36	Asak	a State	Sept Sept Sept Sept Sept Sept Sept Sept								_		

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Samuel 7:00 PM Boyer, IV JANUARY 2006 21, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Baltimore Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Aug. 10, Year) 924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F Minnesota 475-20-3426 81 Director Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow rthan "natural, or Items 23e or 28a-f abov the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Director Baltimore Towson 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Heeith and Mental Hygiene. It is marked other than "natural", or Items 23a or: 21204 6900 Charles Ridge Rd. U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1X() Yes 2 □ No WW II If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Physician Research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edmund Pennell 1 Strothman Jeannette ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian Boyer-wife 6900 Charles Ridge Rd., Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages:
Department of H
Importent: If Ite
eny Injury or ot
once. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Hilltop Serv. Corp 1/23/06 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician 01/21/06 resulting in death) /Medical Due to (or as a consequence of): Examiner NON SMALL CELL CARCINOMA OF THE LUNG 11/2005 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, physicien Physician/Medical the as IF FEMALE: 950 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 ☐Yes 2☐No the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 4 Unknown Completed 1 ☐ Yes 2 ☐ No 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hes autopsy performed? Yes 2X No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient Certification: To 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) in by 1 Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled Hospitel 1 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the h 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 25886 1011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

ILIA CEBALLOS

JAN 2 4 2006

31. Date filed (Month, Day, Year)

D.

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7601

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32, Registrar's Signature

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Secret Secret

DRIVE, TOWSON, MARYLAND 21204

			For State Registrar	State of Ma		artment of rtificate or		nd Mental H	ygiene ()	06	01484
	Dhysisi	7%	1. Decedent's Name (First, Middle, La	•				2. Date of E	-	Vear	3. Time of Death
4	Physici /Medic		WILLIAM SLOCU			- ₁		Januar	$y 20^{ay}, 2$	2006	10:30P [™]
7.8	Examin	er	4a. Facility Name (If not institution, give	e street and number)			or Location of			unty of Death	
	7); 		1420 Front Avenue 5. Social Security Number 6. S	Sev 7 Age	(In yrs. last birthday		erville			Baltimo	
585	Funeral Director			X ² M ² □ F 96		Months Day		Min. April	22, 1909	9 Mass	place (State or Foreign http) Sachusetts
	land ow		10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limits
	Mary Fish	ţō	Maryland Baltimo	re	Luthervi	11e					1 □ Yes 2 □ No
	or 28e	irec	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	
	23a c	Funeral Directo	1420 Front Avenue			2109	3		USA	Д	
	r dea	ner	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin ban, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)	14.1	Race - Americ Black, White,	
36	s afte	by Fu	1 Never Married 2 Married 3XXWidowed 4 Divorced	If Yes, Give Year or Dates:	43-'46	1 □ Yes XX N				ecity: Whit	
8	72 hours atter death with the Maryland natural', or Items 23s or 28e-f show ilsol Examiner must be invittled at	edt	15. Decedent's E		16a. Dece	ident's Usual Occi	upation		16h Kind o	of Business/In	dustry
215	nin 72 in "na	piet	(Specify only highest gr.	ide completed) College (1-4or 5+	(Give	kind of work don DO NOT use retir	e during most o	of working	105.11.10	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2031. y
212	e fited within all Hygiene. other than "	Completed	Lienteritary/Secondary (0-12)	5+		rincipal			Ec	ducatio	on
nd	be filed within 72 hours after death with the Marylan stal Hygiene. od other than "naturel", or lieme 23a or 28e-f show event, the Mudical Examiner man be notified at	To Be (17. Father's Name (First, Middle, Last					Name (First, Midd		name)	
yla	Ment Ment Market	P	Maurice Bigelow B					Agnes Slo			
Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Men Important: if item 27 is marke any injury or other treumatic ones.		19a. Informant's Name/Relationship (Emily Jane Biscoe					o <i>r Rural Route Num</i> timore, M			
Baltimore,	of Hea		20a. Method of Disposition	D	20b. Place of Disponentery, cre	osition (Name of matory or other pi	ace)	Date	20c. Location	on - City or To	wn, State
Ē	Pagement ant: If ury o		1 Burial 2XXCremation 3 Donation 5 Other (Special	y)	GreenMou	nt Cemet	ery 1/	24/06			Maryland
3alt	permit. Pages Department of the Important: If Ite any injury or of once.		2 Signature of Funery Service Lice	nseg/) 2	2. Name and Add		Mitchell-W	State of the state	71.77	
	907 E 90		Mones & yeshon	penake				ork Road Ba		Maryland	
	Physician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. AC	consequence of):						Approximate Interval Between Onset and Death Lweek
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P.O. Box 6	death certific e ettending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome or 1 □ Live birth 2 4 □ Pregna <i>n</i> t at ti 9 □ Unknown	Fetal death 3	⊒Ectopic pregnan □ Other (s <i>pecify)</i>	су			Date of delive Month	ory Day Year
	S 5 0	by	Part II. Other significant conditions	ontributing to death but	not resulting in the u	inderlying cause g	iven in Part I.		tobacco use c		e cause of death?
COL	w require been sig should b	lete		CLEROS				24a. Wa	san 24	Ih Were auto	psy findings available
Re	The lav	Completed						— aut	opsy formed? 22 No	prior to cor death?	npletion of cause of
ita		60	25. Was case referred to medical				26. Place of	1 ☐ Yes Death Check only		1 🗆 Yes	2 No
/	Phyeician; this certific al director,	To B	examiner? 1 ☐ Yes 2 📉 No	Hospital:	2 ER/Outpatie	nt 3 DOA	thor		sidence 6 🗆	Other (Specify	·)
0	ng Ph fter th		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	of 28c. Inju	ury at ork?	28d. Describe	how injury oc	curred	-
sio	or Attending Physician; iffer death. Director; After this certifica in by the funeral director,	cati	2 Accident investigatio				Yes 2□No				
Division of Vital Records,	ei or At after d i Direct d in by	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	reet, factory, office	•	28f. Location City or To	(Street and Nu own, State)	mber or Rura	l Route Number,
	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funers	edicai C	29a. Certifier Check only one) Certifying Ph	nysician: To the best of niner: On the basis of e and manner state	xamination and/or in	h occurred at the ovestigation, in my	lime, data and , opinion, death	place, and due to the occurred at the time	cauco(s) and , date and place	manner as st ce, and due to	utod. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	^	1 .		nse number			ned (Month, i	
	,		Ram	ana Yupu	han M.D		5122	5	1/:	21/20	006
	b		30 Name and address of person who RAMANA UOP	completed gause of dea	ath (Item 23a) (Finoe,	Print) LING (ROSS124	ADS #19	7 BALT	IMOR,	£ 21228
No. of Street, or other Persons	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	W.					

/Medic Examine To the Hospital or Attanding Physician: The lew raquires that the death cartificate be axecuted Division of Vital Records, P.O. Box 68760,

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natures", or thems 23s or 28s-f show

Baltimore, Maryland 21215-0020

	37 14 5 34 17		19b. Mailing Address (Street and Number or Ruret Route Number, City or Town, State, Zip Code)							
	Nadine B. Merkle	(Daughter) 3106 Hernwood Road, Woodstock, Maryland 21163								
	20a. Method of Disposition	20b. Pla	ce of Disposition (Name of		City or Town, State					
	1 Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	metery, cremetory or other place)							
	4 ☐ Donation 5 ☐ Other (Specify)		don Park Cemetery	1/21/2006 Baltin	more, Maryland					
ouce.	21. Signature of Funeral Service License		22. Neme end Address of Fecility							
a	Mantin D Tax	wst)	Mitchell-Wiedefel	ld Funeral Home,	Inc.					
_	Mailli D. Laws	OH	6500 York Road, I	Baltimore, Marvl	and 21212					
	shock, or heart failure. List only one	etions that caused the deeth. e ceuse on each line.	6500 York Road, I	ac or respiratory errést,	Approximate Interval Between					
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Examiner	Sequentially list conditions, if eny, leading to immediate	Due to (or a	as a consequence of):							
<u>18</u>	Cause (Disease or injury c. that initiated events	Due to /our	0		+					
7	resulting in death) Last	Due to (or a	s a consequence of):		1					
Physician/Medical	d									
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2	Part II. Other significant conditions cont	ributing to death but not result	ing in the underlying cause given in Part I.	23b. Did tobacco use co	ntribute to the cause of death?					
Ž	N - CAD)		3 ☐ Probably 4 ☑ Únknown					
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- A		t 1937 >	101.	24a. Was en autopsy	24b. Were eutopsy findings					
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ompiete	Mocoroplase	y (131)	fund Herris		available prior to completion of cause of death?					
e Completed by		4 (1)		1 ☐ Yes 2 💢 No	available prior to					
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			1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death	01486
	Physic /Medi Examii	cal	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 7006 4a. Fecility Name (If-sot) Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	3. Time of Death 3:00PM
	Funeral Director	iler	1303 Sea Shell Ct Baltimore S. Social Security Number S. Social Security	del lace (State or Foreign ltry) sylvania
	p	ctor	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10	0d. Inside City Limits 1 ☐ Yes 2 🖺 No
	s 23e or 28	erai Dire	10e. Street and Number 1303 Sea Shell Ct 21226 United State	es
9000	s 1 and 2 should be tiled within 72 hours after death with the Maryland of Health and Mental Hygiene, itam 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic evant. The Medical Exertifier frust ke notified at	Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Post death 5 for white 6 with 15 for market 15 for m	etc.
121215-0036	tiled within 72 Hygiene. other than "nai ant, the Medic	Complete	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sharpener 18. Mother's Name (First, Middle, Maiden Sumana)	,
Maryland	2 should be tiled within and Mental Hygiene. is marked other than sumatic evant, In a Me	To Be	(11)	Code)
	0 0		Louise A. Cundiff / wife 1303 Sea Shell Ct Baltimore, Maryland 2123 20a. Method of Disposition 1 Burial 2 ® Cremation 3 Bemoval from State 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Tow	26 wn, State
Baltimore,	permit. Page Department o Important: If any injury or once.		West Arundel Crematory 1/19/2006 Odenton, Man 21. Sign stars of Funeral Service Licens 4 22. Name and Address of Facility Ambrose Funeral Home, 1328 Sulphur Spring Rd Arbutus, Maryla	Inc.
	Physician /Medical Examiner		23a. Part 1. Enter the disease, of complications that cause of the death of one of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death) Due to (or as a consequence of):	Approximate Interval Between Onset and Death
8760,	death certilicate be executed e attending physician and of lor use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): d.	
.O. Box 6	that the death certitics ed by the attending pl detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month Description of the past 12 months?	ry Day Year
ords, P	The law requires that the ste has been signed by the bage 2 should be detache	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the	
Vital Record		e Completed	autopsy prior to comperformed? death? 1 Yes 2 No 1 Yes 2	nsy findings available apletion of cause of
Division of Vi	ing Phys Atter this uneral di	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Valural 5 Pending investigation investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No 28b. Time of Injury Work? M 1 Yes 2 No	
Divis	spital or Attand ours atter death saral Diractor: / tilled in by the t	ai Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 29a. Certifier Check onty Check onty Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stall control of the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (s) and the cause (
	To the Hospital of within 24 hours at To the Funeral D completely tilled in	Medical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to to and inflamentation and/or investigation, in my opinion, death occurred at the time, date and place, and due to to and inflamentation and/or investigation, in my opinion, death occurred at the time, date and place, and due to to any inflamentation and/or investigation, in my opinion, death occurred at the time, date and place, and due to to any inflamentation and/or investigation, in my opinion, death occurred at the time, date and place, and due to to any inflamentation and/or investigation, in my opinion, death occurred at the time, date and place, and due to to any inflamentation and/or investigation, in my opinion, death occurred at the time, date and place, and due to to any inflamentation and/or investigation, in my opinion, death occurred at the time, date and place, and due to to any inflamentation and/or investigation, in my opinion, death occurred at the time, date and place, and due to to any inflamentation and/or investigation, in my opinion, death occurred at the time, date and place, and due to to any inflamentation and/or investigation, in my opinion, death occurred at the time, date and place, and due to to any inflamentation and/or investigation, in my opinion, death occurred at the time, date and place, and due to to any inflamentation and/or investigation, in my opinion, death occurred at the time, date and place, and due to to any inflamentation and/or investigation, in my opinion, death occurred at the time, date and place, and due to to any investigation and death of the control	the cause(s)
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Fan Shant Z 2401 Brandermill Blud Ste 250 Grambrills 1	506.
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 2 4 2006 JAN 2 4 2006	(L) 21054.

State of Maryland / Department of Health and Mental Hygiene 15 1487 1- State Registrar Amend item #20b Per FH G851 Gentificate of Death Reg. No.									
			Registrar Amend item Decembert's Name (First, Middle, La	#20b Per FH G	3851 4 <i>9271</i> 9	ge gu Deall	2. Date of Deat	***	3. Time of Death
	Physici /Medio		Marian	Jean Co	moello		JAN	22 2006	7:04P. M
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death					th	4c. County of Death	n		
Funeral 5. Social Security Number 6. Sex / 7. Age (In yrs. last birthday) If Under 1 Year University In the second of the se								9. Birth	pplace (State or Foreign
	Director		791. 28.4.210	1□M 20(F	109 Yrs. Month	s Days Hours Min	(Month, Day,	36 E.S	t. Louis, IL
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Location	^			10d. Inside City Limits
	e Man	ctor	MD BAlti	More	Glen	Arm			1 ☐ Yes 2 No
	with the or 28	Director	10e. Street and Number	. 01	10f. 2	Zip Code	1	0g. Citizen of What Co	untry?
	ter death with the Maryland Iteme 23a or 28a-f show Iner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in t	U.S. 13. Was Dec	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Amer	rican Indian.
98	or ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates:		pecify Cuban, Mexican, Puer 2 DNo Specify:	to Rican, etc.)	Black, White	
Baltimore, Maryland 21215-0036	s 1 end 2 should be filed within 72 hours after death with the Marylar If Health and Mental Hygiene. Itam 27 is marked other then "netural", or iteme 23e or 28e-f show other traumatic event, the Madical Examiner must be notified at	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E		16a. Decedent's Us	A		16b. Kind of Business/I	hite
215	thin 72 e. en 'ne Madik	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give kind of v	work done during most of wo	rking	TOD. KING OF DUSINESSA	O -
121	led will lygien her th		12	5+	Music	Teacher	F	Saltimore 1	Co. Schools
anc	ould be filed with Mental Hygiene arked other the atic avant, the	To Be	17. Father's Name (First, Middle, Last				me (First, Middle, M	faiden Surname)	
ary	2 shoul and Me is mark	۴	19a. Informant's Name/Belationship	Type, Print)	19b. Mailing Addre	ss (Street and Number or R	TAQ C ural Route Number,	City or Town, State, Z	ip Code)
Σ.	1 end 2 Health :		Joseph Compe	110	11132 010	Carriage	Rd., 610	a Aem M	021057
Jore	Pages 1 nent of H int: If Ita iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Disposition (N cemetery, crematory of	rother place) $1/20$	/2006	20c. Location - City or 1	I management
ati.	2 0 3		4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Light	LVU	nstoneral/1		21/060 F	FOREST HI	211
ä	permit. Depart Import any inj		Symbolis (. Zaviotity	EVANS	FUNERAL CHA		HARFURD 16	20.
			23a. Part 1. Enter the disease, or com shock, or hear failure. List only	plications that caused the dea	th. Do not enter the me	ode of dying, such as cardia	c or resolratory arre	ist,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a sechemic	cardionyu quence of):	pathy	<u>-</u>	-	years
	Examiner		Sequentially list conditions	b	quence or).				<i>'</i>
X	be sit	lner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury	Dué to (or as a suriseo	quanta of):				
1	executed in and ial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):				
204 8760		dlcal	(_ d					
191 ox 68	certificate be Iding physicie Ise as the bur	/Med	IF FEMALE:	23c. If yes, outcome of pregn	2000				
€)®	that the death certific ed by the ettending p detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♠ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3 Ectopic			23d. Date of delive Month	very Day Year
ე O	at the	phys	9 ☐ Unknown \	9□ Unknown					
	The law requires that the death sie has been signed by the etter bage 2 should be detached for u		Part II. Other significant conditions of Cerebroves CULAN		sulting in the underlying	cause given in Part I.		accoluse contribute to s 2 □ No 3 1 Pro	
COL	w requ	letec	000000000000000000000000000000000000000				24a. Was ar	Α	
Vital Records,	ilcien: The lav certificete has rector, page 2	Completed by					autopsy perform	ed? death?	opsy findings available ompletion of cause of
رچ Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Other	ath Check only one)	
≥ ₽	S S D): To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 3☐ □	28c. Injury at	lome 5 Reside	nce 6 Other (Speci	m hospiq
3 ion	Attanding r death. sctor: After by the fune	atio	1 ⊠Natural 5 ☐ Pending investigatio		Injury M	Work? 1 ☐ Yes 2 ☐ No			
Division	or Att	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		nome, farm, street, facto	ory, office	28f. Location (Str City or Town	reet and Number or Rur , State)	al Route Number,
50	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier Certifying Ph	nysician: To the best of my kno	owledge, death occurre	d at the time, date and place	, and due to the ca	use(s) and manner as	stated.
	To the Ho within 24 To the Fu	Medical	one) 2 Medical Exam	miner: On the basis of examina and manner stated.	ation and/or investigation	on, in my opinion, death occu	irred at the time, da	te and place, and due t	to the cause(s)
	To To COL	-	29b. Signature and title of certifier	2120		9c. License number D 58 30 3		d. Date signed (Month,	
	J,		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print)	2 - 0 - 0 5		J (ve y 2)	, , , , ,
=	\		A HOLEN CHAPLIES	, no 6601 1	N. Charles	D58303 St Baram	ne mo	21204	_4
	Sta Registr		31. Date filed (Month, Day Year) JAN 2 4 20	Registrar's Sign	BILLIE AT LE				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Year 06 **Physician** am25 Corns 125 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Rehabilitation Extended Care Ba(fimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1**√2** M 2□ F Days Hours Yrs. 218-10-0771 93 MAryland Director February 15,1912 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h Count "natural", or itema 23e or 28a-1 show edical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Dundalk MD Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 6807 Bessemer Avenue death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1♥1 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Painter 8 years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Bertha Doval David H. Corns 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 105 Gorsuch Road, Timonium, MD. 21093 Health a Madlyn Francis permit. Pages 1 and Department of Health Important: If item 27 any injury or other 1 once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State January 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 25, 2006 Dundalk, MD. 22. Name and Address of Facility Lorente Of Dundalk, P.A. Connelly Funeral Home Of Dundalk, MD. 21222 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Dy not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dementia **Physician** unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical use as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed3 certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 3 No To the Hospital or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 70 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 34359(0H10)

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ohn S. Loh, m.D. 3900 Loch Roven Boulevard, Beltimore, Margland 21218

1. Date filed (Month, Day, Year)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year **Physician** Month 7:00 PM JR Jeck 2006 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimor Norsing orien-Frankford If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 100M 20F Days SC February 6, 1936 Director 216-32-1656 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is markad othar than "natural; or Items 23a or 28a-f shov traumatic avant, the Madical Examinat must be notified at 1 Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 USA St. 501 -Apt. 121, Dol Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Black 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 72 h and Mental Hygiene. 7 is marked other then "ns (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer 1246 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Damuel Gladys Cleckley Department of Health and I be Important: If item 27 is ma any injury or other traumat Once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlo Cleckley-Grady/Daughter 6119 St. Regis Road, Baltimore, MO 21206 20a. Method of Disposition

1 Surial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MD Zion Cem. 4 □ Donation 5 □ Other (Specify) January 28, 2006 Baltimore 22. Name and Address of Facility
Hari P. Close Funeral Service, P.A.
5126 Belair Road, Baltimore MD 21206-5105 21. Signature of Fun ral Serve Licens Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line, Immediate Cause (Final Physician epatocellular CAVUNGMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a gonsecturings of Examiner flag, Lading to in needed cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ VASCULAV & IS EASE neval 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ inknown Be Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 TYes Hospital or Atlanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Thomicide a Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Tight defining in section in the line of the cause of the (Check only one) tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 Mulli 2006 102 W() JANUARY

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

5901 north charles

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DON M.D.

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 5 per fh 9852 2-3-06 vt.
State of Maryland / Department of Health and Mental Hygiene 01692 1 - For State Registrar Certificate of Death Reg. No 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 17, 2006 1240 Teresa Beltran Crespo 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Secrety Number 6. Sex Days Months 1 ☐ M 2 🂢 F 65 Yrs 578-50-6430 15. 1940 Bolivia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 No Maryland Rockville Montgomery 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 20852 United States 402 Hull Place 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 X Yes 2 □ No Specify. Specify 3 Widowed 4 Divorced **Bolivian** White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private School Teacher's Aide 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Julio Beltran Yolanda Lougon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diego R. Crespo/Husband 402 Hull Place, Rockville, Maryland 20852 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place)
Montgomery January 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 21, 2006

Bethesda, Maryland
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
anter the mode of thing such as a constant and anter the mode of thing such as a constant and anter the mode of thing such as a constant and anter the mode of thing such as a constant and anter the mode of thing such as a constant and a 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. 21. Signatur of Funeral Strvice Licensee Bethesda-Chevy Cha Bethesda, Maryland M00803 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARRYTHMIA CARDIAC Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? BLEED 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown GASTRO INTESTINAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes TRACT INFECTION 2 No 1 Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No М 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

/Medical Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or itema 23a or 28a-1 show the Medical Examinar must be notified at

Director

Funeral

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Completed

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Examiner

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Completed

Certification:

death with the Maryland

filed within 72 hours after

Il Hygiene.

permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygier Important: If Item 27 ie marked other th any injury or other traumatic event, Illa once.

Physician

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit Records, P.O. Box 68760 detached Division of Vital al or Attending Physician: 's after death.
I Director: After this certifica of in by the funeral director, p filled in by To the Hospital or within 24 hours aft To the Funeral Di completely filled in

SCLERODERMA URINARY 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 🗌 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certifier

29c. License number D 35941 29d. Date signed (Month, Day, Year)

RUCKVILLE, MO 20052

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JANUARY 17, 2006

P. MATHUR 50 W. GOMUNSTON DR. # 401 PURAN

31. Date filed (Month, Day, Year)

JAN 2 4 4 2006

, M.D.

egistrar's Signature

State

Registrar

		•	For State of Market State Stat	-	epartment of H Certificate of I			/1111b	0 4 9 3
			Decedent's Name (First, Middle, Last)		Joranouto or i		2. Date of Death Month JANUARY	No. Year	3. Time of Death
	Physici /Medic	al	JUDITH		COHEN			21, 2006	6:20 AM
	Examin	er	4a. Facility Name (If not institution, give street and number) HOSPICE OF BALTIMORE GILC		, ,	r Location of Death TOWSON		4c. County of Death	LTIMORE
	Funeral		5. Social Security Number 6. Sex 7. Ag	ge (In yrs. last birth	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Y.	9. Birth	place (State or Foreign intry) MD
0000	Director		Usual Residence of Decedent				MAI 10,1	1930	
00	Aarylan f ehow	ō	MD BALTIMORE	10c. City, Town	or Location IMORE				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
83	ith the Maryla or 28a-f ehor	Director	10e. Street and Number	DALI	10f. Zip Code		10g	. Citizen of What Cou	
SE		ralD	10-B FOURWOOD COURT	5 :: 110		21209	7	14.0	USA
ny 21	72 hours after death v neture!; or Items 23s	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ammed Forces? 1 Never Married 1 Never	No	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	Rican, etc.)	14. Race - Amer Black, White Specify:	
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and	be filed htal Hygi od other event, I	Be	17. Father's Name (First, Middle, Last) JACK ISADORE	D	ROTHERS	18. Mother's Name RACHAE		iden Surname)	TRAUB
Cohen Marylan	2 should be filed with and Mental Hygiens Is marked other the surnatic event, the	P_	JACK ISADORE 19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street			ity or Town, State, Z	
	ges 1 and 2 should be illed within 72 ho t of Health and Menial Hygiene. If item 27 le marked other then "netu or other treumatic event, the Medical		GERALD COHEN / HUSBAND		-B FOURWOOD				
Judith Baltimore,	Pa men ant: ury		20a. Method of Disposition 1		Disposition (Name of crematory or other place HALOM MEMOR	RIAL 01/2	2/2006		TOWN, MD
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			23a. Party. Enter the disease, of complications that cause shock, or heart failure. List only one cause on each li	,		ng, such as cardiac or	r respiratory arrest	,	Approximate Interval Between Onset and Death
•	Physician /Medical		disease or condition	a consequence of	incer		<u> </u>		Years
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Ē	ne Hospit n 24 hour ne Funera	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination and	death occurred at the tir for investigation, in my o	me, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the Comp	Σ	29b. Signature and title of certifier		29c. Licens		29d	. Date signed (Month	. Day, Year)
	0		30. Name and address of person who completed cause of c	death (Item 23a) (T		51926	1-1	iernary 2	1, 2000
	10		Helen M-Gardon 6565	N. Cha	iles St, Bal	Hunche of	UD 2120	4	
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 4 2005	rar's Signature	les de				

eslie Cohen 06-0485 NKG

Physician /Medical Examiner Funeral Director

permit. Peges 1 end 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other treumatic event. It a Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours atten death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Prin Unpend item#23a,27,pen/FL (351.1 State of Ma	nt in Black Indeli /30/06 TT aryland / Departm	ble Ink. Ensure A ent of Health and N	II Copies Ard Mental Hygier	e Legible.	011-01			
1 - State Registrar		ate of Death	Reg. I	6000	01434			
1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death			
	COHEN			20, 2006	8:45 A M			
4a. Facility Name (If not institution, give street and number)		City, Town, or Location of Death		4c. County of Deat				
7713 East Winterwood Court 5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday) If U	Severn nder 1 Year If Under 24 Hrs.	P Date of Ridh	Anne Aru	tholace (State or Foreign			
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Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location				10d. Inside City Limits			
MD ANNE ARUNDEL	SEVERN				1 ☐ Yes 2 🔀 No			
10e. Street and Number	10f	. Zip Code	10g.	Citizen of What Co	ountry?			
7713 EAST WINTERWOOD COURT		21144			USA			
11. Marital Status 12. Was Decedent \(Ammed Forces? \) 1 □ Never Married 2 □ Married 1 □ Yes 2 □ \(\frac{1}{2} \)	Ever in U.S. 13. Was D If Yes,	ecedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit				
If Yes, Give Year or Dates:	1 □ Y€	s 21X No Specify:		Specify:	WHITE			
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17. Father's Name (First, Middle, Last)	JEONETAN		e (First, Middle, Maid					
EDWARD	VANE	JUANIT	Α		MORAN			
19a. Informant's Name/Relationship (Type, Print)		ress (Street and Number or Rui						
SHARON M. METCALF / SISTER	20b. Place of Disposition	HORNE AVENUE -		Location - City or				
1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	cemetery, crematory	or other place) IEBREW CEM 01/2		ISTERSTO				
21. Signature of Funeral Service Licensee		1111 15 70	L LEVINSON					
> Scott VII. Cittle	L 8900	REISTERSTOWN						
23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not enter the ne.	mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death			
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Due to (or as	a consequence of):							
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cause. Enter Undertying Cause (Disease or injury that initiated events c								
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IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant				23d. Date of de	livery			
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9 Unknown Part II. Other significant conditions contributing to death b	ut not requiting in the underbi	ing gauge group in Part I	23e Did tobaco	o use contribute to	the cause of death?			
	at not resulting in the anderly	ng cause given in Fait i.	1 Yes		robably 4 Unknown			
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			autopsy performed	prior to death?	completion of cause of			
25. Was case referred to medicat			th (Check only one)					
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27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Inju (Month, Da)	ry y Year) 28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ijury occurred				
3 Suicide 6 Could not be determined 28e. Place of Injuried	ury - At home, farm, street, fa		28f. Location (Street		ural Route Number,			
Building, 9t	c. (Specify)		City or Town, St	a(0)				
29a. Certifier (Check only one) 2. Manner of Death 1. Natural 5. Pending investigation 6. Could not be determined 28e. Place of Inj building, et	f examination and/or investiga	rred at the time, date and place, ation, in my opinion, death occur	and due to the cause red at the time, date a	o(s) and manner as and place, and due	s stated. to the cause(s)			
29b. Signature) and title of certifier	ated.	29c. License number	29d. I	Date signed (Mont	h, Day. Year)			
& Lorh o MD	0.C.M.E. January 21, 2006							
30. Name and address of person who completed cause of d		4 5						
J. LARON LOCICE, M.	4	1 Penn Street,	Baltimore	, Maryla	nd 21201			
31. Date filed (Month, Day, Year) JAN 2 4 2006	ar's Signature							
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DHMH 17 Rev 1/2001

Stat Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Yee DAVIS **Physician** MARY 10:03 AM JANUARY 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner KANDALLSTOWN BALTIMORE NORTH WEST HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | Month, Day. 7. Age (In yrs. last birthday)
Yrs. 9. Birthplace (State or Foreign Country)

Maryland 5. Social Security Number **Funeral** 1 ☐ M 2 🛛 F 12-3728 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location other than "natural", or iteme 23a or 28a-f ehow vent, the Medical Examiner must be notified at 1 Yes 2 No Maryland 10e. Street and Number Director more 10g. Citizen of What Country? 10f. Zip Code Unit more Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Vor 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental 2 samue 19a. Informant's Name/Relationship (Type, Print) (SOn) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar important: if item 27 is any injury or other trai-21229 VIC TIC TO. IVIA 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition gemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ma. Nationa 4 ☐ Donation 5 ☐ Other (Specify) 21. Signuture of Funeral Service Licenseq 22. Name and Address of Facility Balto. W. North Ase Approximate Interval Between Onset and Death 23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shockly, or heart failube. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year ģ Month Day 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 4 Hunknown CHRONIC RENAL 3 ☐ Probably FAILURE 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? INFARCTION 24a. Was an MYOLARPIAL autopsy performe 2 No 1 Yes 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Director: Aftar th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide

Division of Vital Records, P.O. Box 68760

within 24 hours efter To the Funerel Dire 3

> State Registrar

Medical

4 - Homicide

29b. Signature and title at certifier

29a. Certifier

30. Name and horress of person who completed cause of death (Item 23a) (Type, Print) LECNARD RICHARDSON M.D. 5401 OLD COURT ROAD CANDAUSTOWN MD 21133



and manner stated.

1 🖳 Comitying Physician- Thithe best of my knowledge ideath occurred at the time, date and place, and due to the racea(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D57722

29d, Date signed (Month, Day, Year)

2006

JANUARY 20

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

M.D.

Peter D. David Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-0417 State of Maryland / Department of Health and Mental Hygiene AKG Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jänuary 16, 2006 4:10 P M Peter Danny David /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3505 Keswick Road Baltimore
If Under 1 Year | If Under 24 Hrs. n/a 8. Date of Birth (Month, Day, Year) Jan. 18, 1 9. Birthplace (State or Foreign Country) California 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 59 1**X** M 2□ F 568-62-7244 Yrs. 1946 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28s-f show the Medical Examiner must be notified at Baltimore N/A 1 TYes 2 □ No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3505 Keswick Rd. 21211 U. S. A. or Itams 23a Completed by Funeral be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1964 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1 ⊠ Yes 2 □ No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify 3 ☐ Widowed 4 ♣ Divorced White 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Gun Smith <u>Sales</u> of Health and Mental Hygie filtem 27 is marked other t ir other traumatic avent, the permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any injury or other traumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peter James David Lavonne (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul David, son 2822 Florida Ave. Baltimore, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Veterans Cemetery of 01-20-06 Crownsville Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Ambrose funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne, MD. 234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** theischis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine or Attanding Physician: The lew requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medicai use as the ettending i IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 12 Inknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of d ath?

1 at ves 2 □ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: $_{4\,\square\,\text{Nursing Home}}$ 5 $_{\Box}$ Residence & Other (Specify) at SCENE 1 XYes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To this 28a. Date of Injury (Month, Day Year) : After thi 27. Manner of Death

1 Natural
2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Yes 2 No nours effer death, nars! Director: A filled in by the fr death. investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital of within 24 hours of To the Funers! Discompletely filled in 1 Certifying Physician: To the best of my knowledge death occurred at the time date and place, and due to the date (s) and manner at stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 239 Certifier Medicai (Check only and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 17, 2006

State Registrar THE OD LE MICHA 31. Date filed (Month, Day, Year) INN 2 4 2

DHMH 17 Rev 1/2001

111 Penn Street, Baltimore, Maryland

ss of person who completed cause of faun (Item 23a) (Type, Print)

2006

32. Registrar's Signatura

	n succe so		1 - For State Registrar	State of Maryla		artment of l rtificate of			giene 006	01497
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Alfred Courtrite					2. Date of Dea Month Januar	Day Year	3. Time of Death 0017 M
	Examir		4a. Facility Name (If not institution, give s Shady Grove Adve	ntist Hospit		Rockvi			4c. County of Dear	ry
	Funeral Director		5. Social Security Number 233-40-3936 Usual Residence of Decedent	7. Age (in y	rs. last birthday)	Months Days		Month, Da	9. Bird 3, 1931 Wes	thplace (State or Foreign suntry) t Virginia
	the Marylend r 28e-f ehow notified at	rector	10a. State 10b. County Maryland Montgomer 10e. Street and Number		City, Town or Lo				10g. Citizen of What Co	10d. Inside City Limits 1√√ Yes 2 □ No puntry?
036	72 hours after death with the Marylend "natural", or itams 23a or 28e-f ehow officel Exeminer must be notified at	by Funeral Director	747 Owens Street 11. Marital Status 1 Never Married 2 AMarried 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Mayes 2 No Ko If Yes, Give Year or Dates: Vj		2085 Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 No	Hispanic Origin? (Span, Mexican, Puer	Specify Yes or No to Rican, etc.)	Black, Whit	erican Indian,
121215-0036	f within 72 jene. r then "ns	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occu b kind of work done DO NOT use retire	during most of wo		United Sta	
Maryland	d a b	To Be	17. Father's Name (First, Middle, Last) Alfred Courtrite		405 14.11	A 14 (6)	Margare	et Matilo	Maiden Sumame)	
Baltimore, Mai	is 1 and 2 of Health av item 27 ie other trau		19a. Informant's Name/Relationship (Ty, Anne Louise Dobbs, 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	/Wife	747 D. Place of Dispo cometery, cre crlingto Ce	Owens St osition (Name of malory or other plant on Nation metery	reet, Rocal	ckville, Date 1 13,	20c. Location · City or Arlington,	20850 Town, State Virginia
Balt	permit. Page Department of Important: if eny injury or once.		21. Signatur 1 uneral Service Libenso		0803 R	^{2. Name} and Addr ockville ockville	ess of Facility Ro , Inc. 3(, Marylar	obert A. 00 West M nd 20850-	Pumphrey F Lontgomery -2805	uneral Home/ Avenue
68760,	Physician //Medical Examiner per prize pri	ical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. Lary learning to an individual cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Myocardia Due to (or as a cons	al Infar sequence of:			o or respiratory an	1031,	Approximate Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed site has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	□Ectopic pregnand □ Other (specify)	гу		23d. Date of del Month	ivery Day Year
Ś	quires that n signed by uld be deta	b	Part II. Other significant conditions cor	ntributing to death but not	resulting in the t	anderlying cause g	ven in Part I.		obacco use contribute to	
al Record		Completed						24a. Was autop perfo 1 \(\text{Yes}		utopsy findings available completion of cause of
on of Vital	ding Physicien: Th th. After this certificete funeral director, pag	tlon: To Be	25. Was case reterred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	ER/Outpatie	of 28c. Inju	her: 4 🗆 Nursing I	1	dence 6 Other (Spe	cify)
Division	ist or Attending s efter death. et Director: After ed in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.				28t. Location (S City or Tox	Street and Number or Re vn, State)	ural Route Number,
	To the Hospital of within 24 hours of To the Funeral D completely filled in	Medical (29a. Certifier 1X Certifying Physical Check only one) 2 Medical Examin	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	th occurred at the nivestigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and manner as date and place, and due	s stated. to the cause(s)
)	To t comp	Σ	29b. Signature and title of certifier	~ m?.		29c. Licer	se number	5	29d. Date signed (Mont January 17	
	407		30. Name and address of person who construction Sunil Saxena, M.	D. 9901 Med	lical Ce		ve, Rock	ville, Ma		850
1,0	Sta Regist		31. Date filed (Month, Day, ¥ear)	32. Registrar's Si	gnature	3/1				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15amm Month ,2006 andla januara 1Xon 33 4b. City, Town, or Location of Deathy Facility Name (If not institution, give street and number) 4c. County of Death HMORE RUIAna 7. Age (Frank, last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Seedrity Number 8. Date of Birth Birthplace (State or Foreign Country) 6 Sex Min 1 □ M 2 💢 F Days Hours May Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1√Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? . Was Decedent Ever in U.S. Armed Forces?. 1 — Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 25 Alo. Specify: dace 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life). DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) moths Elementary/Secondary (0-12) College (1-4or 5+) House N/A17. Father's Name (First, Middle, Last) Name (First, Middle, Maiden Sumame) enes 19aoInformant's N. me/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) aughter 320 BelmontA 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Lice tion - City or Town, State cemetery, crematory or other place. Burial 2 Cremation 3 Removal from State md. Mem. ndelstown 4 □Donation 5 □Other (Specity) 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility 2/229 Enter the guease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. palto.md. Approximate Interval Between Onset and Death shock, or heart Immediate Cause (Final disease or condition resulting in death) Due to (or as Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

attending physician and for use as the burial-transit

ed by the a

After t

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

the Hospital or Attending Physicism: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Department of Health a Important: If Item 27 is eny injury or other traisone.

Physician

/Medical

10a State

Examiner

Funeral

Director

r then "natural", or items 23a or 28e-f ehov the Medical Examinar must be notified at

is marked other then

Pages 1 and 2 should be nent of Health and Mental

death

filed within 72 hours after

Baltimore, Maryland

Completed by Funeral Director

Be

Examiner

Be Completed by Physician/Medical

2

Certification:

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

4 Unknown 1 Yes 2 No 3 Probably

24a. Was an autopsy performed?

22 No 1 Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25.	Was case examiner?	referred	to r	nedical
	1 Yes	2 🗆 No		

27. Manner of Death 1 Natural 5 Pending investigation 2 Accident

6 Could not be determined

1 Inpatient 28a. Date of Injury (Month, Day Year)

2 PR/Outpatient 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28c. Injury at Work?

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DU2510

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 Homicide

29b. Signature and title of certified 29c. License number

Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

emon MI)

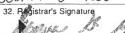
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) *luthu* Krishn -Kumar

821 N. Eutaw St

Registrar

31. Date filed (Month, Day, Year) 4 2006

Hospital:





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			For State	-	epartment of Health and M	ental Hygier	enne nilge
			Registrar	(Certificate of Death	Reg. I	
	Phonisis	_	1. Decedent's Name (First, Middle, Last)	1.0.		2. Date of Death Month	3. Time of Death
	Physici /Medio		Kuth Yok	SEY	1	Pour 1	& 06 9.55PM
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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	nday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign
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			Usual Residence of Decedent				
9	a s		10a. State / 10b. County	10c. City, Town	or Location		10d. Inside City Limits
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1	288	ec 1	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Country?
4	0 9	0	860 1) Hillon	Street	21329		CISA
-	/2 hours affer death with the Maryland naturel', or liems 23s or 28s-1 show Jical Examinar must be notified at	Funeral Director	11. Marital Status 12. W	/as Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - American Indian,
		Ę	A	med Forces?	If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White, etc.
36	e 9 6	by	3. Widowed 4 □ Divorced Y	☐ Yes 2 No Yes, Give ear or Dates:	1 ☐ Yes 2. No Specify:		Specify: AMERICAN
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Maryland	s 1 and 2 should be lied within 72 hours affer death with the marylan if Health and Menhal Hygiene. If Health and Menhal Hygiene. Item 21 is marked other than "naturet", or liems 23a or 28a-f show other treumatic event, the Medical Examination and be notified at	ဥ	KUSSELL DENI		MARY	HENRY	T. O. I. T. O. I.
Jar	and is m		19a. Informant's Name/Relationship (Type, F	(rint) 19b.	Mailing Address (Street and Number of Rura	/	or Town, State, Zip Code)
	and ealth n 27 rer ti		PELICE Smes-	chaptier 800		amore M	44 AND 21229
altimore,			20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Remove	cemetery	Disposition (Name of c, crematory or other place)	ate 20c.	Location - City or Town, State
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Ħ	permit. Page Department of Importent: If any injury or QDCE.		21. Signal re of Funeral Service Licenses		22. Name and Address of Facility NANCY M. WALLACE FLAT	and SORU	ce /
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١.		. 1	shock, or hear failure. List only one ca Immediate Cause (Final	use on each line.			Onset and Death
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	Examiner			ue i (or s a consequence	00		
		_	Sequentially list conditions, if any, leading to immediate	Due to the a consequence of	£\.		
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760,	e be execut rsician and e burial-tran			Due to (or as a consequence of	.).		
376	nysic he b	ical	d				
68	The law requires that the death certilicate ite has been signed by the attending physioage 2 should be detached for use as the to	by Physician/Medi	IF FEMALE:				
Вох	h ce endii	Ž	23b. Was decedent pregnant 23c. If	yes, outcome of pregnancy □Live birth 2 □ Fetel death	3 Ectopic pregnancy		23d. Date of delivery
<u>m</u>	deat d for	10	in the past 12 months?	Pregnent at time of death	5 Other (specify)		Month Day Year
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σ.	that ned t	y P	Part II. Other significant conditions contribu	ting to death but not resulting in	the underlying cause given in Part I.	23e. Did tobaco	o use contribute to the cause of death?
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<u> j</u>	ysicien: is certific director,	Be	25. Was case referred to medical examiner?	tal:	26. Place of Death	(Check only one)	W ====================================
Division of Vital Records,	≥ S D	2	1 Yes 2000 Hospi	1 inpatient 2 EH/Out			6 ☐ Other (Specify)
-	ding Pt. After th funeral	ü	27. Mann of Death 1 Natural 5 ☐ Pending	ta. Date of Injury 28b. Ti (Month, Day Year) In	jury Work?	8d. Describe how in	jury occurred
.0	ottendia death. ctor: A y the fu	ati	2 Accident investigation		M 1 Tyes 2 No		
<u> </u>	Atto	ij	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28	e. Place of Injury - At home, fari building, etc. (Specify)	m, street, factory, office	Bf. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	s afte	Certification:			<u> </u>		
	To the Hospitel or Atten within 24 hours after deat To the Funeral Director: completely filled in by the				death occurred at the time, date and place, a		
	B Fu	Medical		and manner stated.	vor investigation, in my opinion, death occurre		ind place, and due to the cause(s)
	To the h within 2, To the f complet	ž	29b. Signature and title of certifier	2 1 1	29c. License number	29d. [Date signed (Month, Day, Year)
	->-0		1 0 0821	200X11	DH TOH H	10	1. 20 pt
í l	1		30 Name and address of the	eted cause of death (Item 23a) (1	Type Brint)		
			30. Name and address of person who completely a completely and address of person who completely a completely a completely a completely and a completely a complet	521 11 5	1 1 11 11 11	mare Ma	land -7, 201
	1		31 Date filed (Month Day Voor)	32. Registrar's Signature	MAN STICES . ISTALLI	more IIIA	approximation
		ate	31. Date filed (Month, Day, Year)	SZ. Fiogistial S Signature	1		
	Regist	all	JAN 2 4 200	6 James James	(1841)		
DHN	AH 17 Rev 1/2	001		3			

State of Maryland / Department of Health and Mental Hygierie 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** SUANNEN KATHERINE January 19 2006 12:20 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1624 Cereal Street Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 16, 1 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🗓 F 214 30 3295 92 1914 **Director** Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and them 27 Is marked other than "natural", or Items 23e or 28e-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or Items 23e or 28e-f show traumatic event, the Medical Examinar must be notified at 1 ▼ Yes 2 No Maryland N/A Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1624 Cereal Street U.S. 21226 Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 5th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Casimir Zebron Lucina Mikolajczak ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra Barbara Victor / Daughter 1618 Hazel Street Baltimore, Maryland 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 1/23/2006 Baltimore, Maryland • 4 □ Donation = 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signators of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 amerous 23a/ Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician TA 60 8 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ATHEROSC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 menths? Month Day 4□Pregnant at time of death 5 Other (specify) Ö the 9 Unknown signed by Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 10 24a. Was an has autopsy performed? Yes 200N 2 1 Yes Division of Vital To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 \(\text{Yes} \) Yes Be 26. Place of Death (Check only one) Other: Hospital: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: or Attending 5 Pendina death. 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funerel [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifer 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KICHAR 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar